Dear Reader:

We are pleased to share with you the latest draft of the *KyHealth Choices* 1115 demonstration waiver application submitted to CMS on November 4, 2005. We anticipate making changes to this draft as we receive questions and feedback from the Center for Medicare and Medicaid Services (CMS).

Sincerely,

Shannon Turner

Commissioner Shannon R. Turner
Department for Medicaid Services

KyHealth Choices

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The Transformation of Kentucky Medicaid

Executive Summary

In recent months, the Kentucky Cabinet for Health and Family Services (CHFS) has set the stage for a major transformation of the Kentucky Medicaid program. This transformation, entitled *KyHealth Choices*, began with the development of a strong infrastructure which included improvements to the MMIS (Medicaid Management Information System), pharmacy benefit administration and the Department's utilization management and clinical review process. The Commonwealth now seeks to continue this transformation by emphasizing and building upon the partnership between Kentucky Medicaid and each of its members through an application for an 1115 Medicaid Waiver from the Centers for Medicare and Medicaid Services (CMS). Once completed, Kentucky envisions a new Medicaid program that will improve the health status of those Kentuckians enrolled in the program and ensure a continuum of care and individual choice.

To accomplish this vision, Kentucky has worked in partnership with consumers, family members, advocacy organizations and providers to set two major goals:

1) Stretch resources to most appropriately meet the needs of recipients; and
2) Encourage Medicaid members to be personally responsible for their own health care.

Considering the number of recipients within the Kentucky Medicaid program and the amount of resources expended on their healthcare, it is imperative that services be provided in the most efficient and cost-effective manner possible. For that reason, Kentucky proposes to maximize its resources by developing varying benefit packages designed to meet the needs of the different populations served and to establish meaningful benefits based on best practice standards.

Additionally, Kentucky will ensure Medicaid is the payor of last resort by encouraging those Medicaid members who have access to private insurance coverage or Medicare to utilize that option of coverage before Medicaid. Another strategy within the proposed demonstration waiver will include strengthening the Commonwealth's Health Insurance Purchasing Program (HIPP), which determines whether it is more cost-effective to assist individuals with access to

private coverage in purchasing that coverage and using Medicaid to wrap-around those services.

Kentucky will leverage the commercial market creating both cost-savings and improved healthcare delivery system practices. This objective will be obtained by filing a state plan amendment to redesign the Kentucky Children's Health Insurance Program (KCHIP). The amendment will transform KCHIP from a Medicaid look-alike program to a stand alone program and bid out the provision of services to private insurance companies.

The vision of a transformed Kentucky Medicaid program includes the provision of care that is better integrated. Through *KyHealth Choices,* members will realize improved coordination of mental health, mental retardation/developmental disabilities, substance abuse services and physical health services.

Kentucky Medicaid recognizes that the individual can and should play a central role in purchasing and planning for their own health care needs. Through *KyHealth Choices* members will recognize the role they play in reducing healthcare cost by making more conscientious choices – choices that result in their continued wellness. Each member will be assisted by professional staff and will come to rely on Kentucky Medicaid to assure access to quality healthcare options in order to fulfill their wellness goals.

Perhaps one of the most exciting aspects of *KyHealth Choices* is the creation of Get Healthy Accounts (GHAs). Get Healthy Accounts will allow individual members who have specific targeted diseases to earn funds by participating in certain healthy practices as identified by the Commonwealth. Such activities may include annual exams or disease management protocols. The individuals may then access the accounts to purchase additional health care services, assist with cost-sharing requirements, or purchase gym memberships, smoking cessation programs or other traditionally non-covered services under Kentucky Medicaid.

KyHealth Choices will ensure that education and choice counseling is available to all Kentucky Medicaid members in an effort to assist them in making the best choice among benefit packages and will structure their benefit packages to assure a continuum of care to maximize the use of services provided in an individual's home.

The 1115 demonstration waiver proposal, *KyHealth Choices,* will ultimately transform Kentucky Medicaid to result in the better utilization of available resources, while at the same time ensuring members have the opportunity to make meaningful choices about their own healthcare. This proposal will allow the Commonwealth of Kentucky the opportunity to test a new, innovative, and transformed Medicaid program. This demonstration project is imperative to the future success and sustainability of the Kentucky Medicaid program.

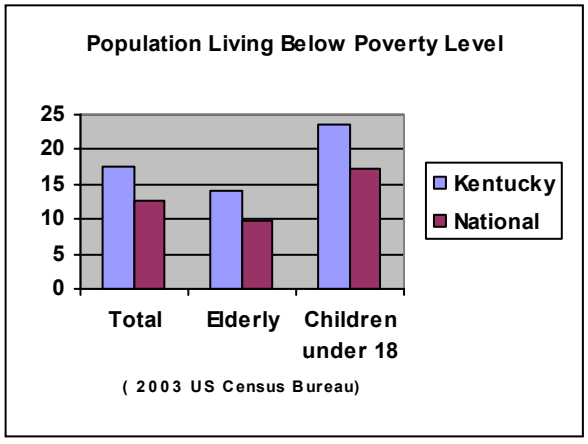
KyHealth Choices

Chapter One: Background

In January 2004, Governor Ernie Fletcher began his administration facing a significant deficit within the Kentucky Medicaid program. He immediately charged the Cabinet for Health and Family Services (CHFS) to develop opportunities to contain the escalating costs, while at the same time ensuring the quality provision of medically necessary services to the Commonwealth's most at-risk citizens. In less than 19 months, the Fletcher administration has conducted a thorough assessment of every program and service provided by Kentucky Medicaid. Through this process, areas were identified in which improvements and efficiencies could be obtained. Additionally, steps were initiated to modify the Medicaid infrastructure to better support a significant transformation of the entire system. The Commonwealth now seeks to continue this transformation by emphasizing the partnership between Kentucky Medicaid and each of its members through the application for an 1115 Medicaid Waiver, *KyHealth Choices*, from the Centers for Medicare and Medicaid Services (CMS).

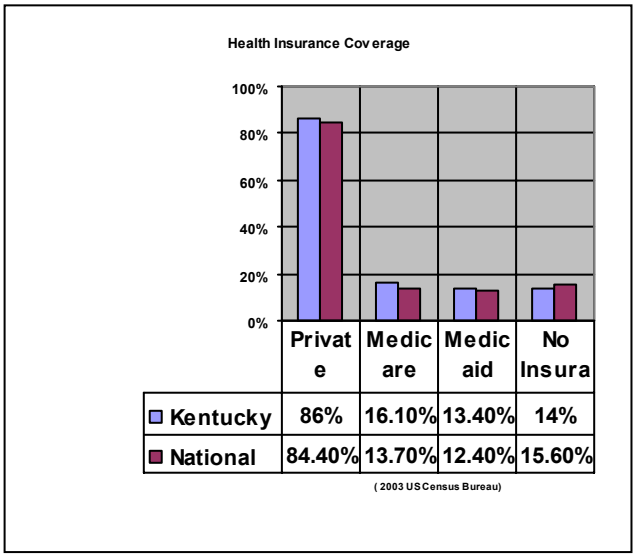
Kentucky Demographics

Recent data shows Kentucky to have one of the highest percentages in the nation of residents living below the poverty level. Unfortunately, a large portion of those living in poverty are the elderly and children, with Kentucky ranking 4th and 6th in the nation in these areas. Additionally, it is estimated that another 20% of the state's children live in families with incomes below 200% of the federal poverty level ($30,520 for a family of three). Kentucky ranks 47th in the nation in median household income, currently $34,368 compared to the national median household income of $43,564. Currently considered one of the least healthy states in the nation, Kentucky ranks at or near the top of all states in cancer and cardiovascular deaths per 100,000 residents, and ranks second in overall mortality. The state's obesity level is 6th in the nation while the incidence of diabetes ranks 7th.



Kentucky Health Insurance Status

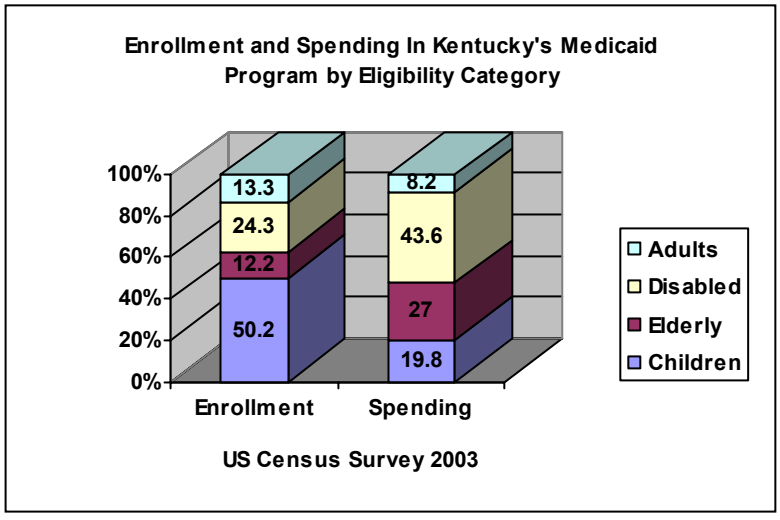
Health insurance coverage in Kentucky closely mirrors the national average. U.S. Census Bureau statistics for 2003 indicate 84.4% of the U.S. population and 86% of Kentuckians were covered by some form of health insurance. Medicare and Medicaid coverage in Kentucky is slightly higher than the national average while private insurance coverage is identical. The number of Kentuckians without health insurance is slightly less than the national level, 14 to 15.6%; however, that still accounts for more than half a million Kentuckians without insurance coverage.



Kentucky Medicaid

The Kentucky Medicaid program was established in 1965 under Title XIX of the Social Security Act. The program is operated in much the same manner as other states, with the state taking the lead in structuring coverage, establishing nominal cost sharing, and making direct payments to providers. Currently, there are approximately 691,000 enrollees in the Kentucky Medicaid program, representing more than 15% of the state's total population an increase of almost 3% in the last two years.

Kentucky Medicaid covers 1 out of every 2.5 births (44%) and provides health coverage to 1 out of every 3 children and 1 out of every 7 seniors over age 65.



At the same time, Kentucky Medicaid spends a smaller portion of its budget on administrative costs than any other state Medicaid program.

The progress Kentucky has made to date in transforming its Medicaid program continues to be threatened by state budget problems.

Kentucky Medicaid's expenditures are consuming an ever increasing proportion of the Commonwealth's budget and currently accounts for approximately 22% of its annual expenditures, making it the second largest state budget item after education. Approximately 11.4% of Kentucky's state general fund dollars were expended on its Medicaid program in state fiscal year (SFY) 2005.

While progress has and is being made, there are also factors at work which serve to constrain and impede the Commonwealth's ability to make meaningful and enduring improvements to its Medicaid program. For example, current federal polices require each state's Medicaid benefit package be the same for all populations regardless of their need or medical condition. In addition, there are no incentives for our Medicaid population to assume personal responsibility for their use of services or for seeking services in the most cost-effective venue. Thus, these issues, along with federal cost containment initiatives currently underway have left the Commonwealth with a $425 million deficit that must be addressed. While *KyHealth Choices* will not address Kentucky's FY05-06 Medicaid budget deficit, it will transform the program to prevent future budget imbalances and ensure long term solvency.

Current Waivers

Sixteen counties in the Louisville region of Kentucky are currently operating under an 1115 waiver administered by Passport Health Plan. This waiver allows members residing in those counties to be served by a managed care organization. None of the members being served under Passport will be affected by *KyHealth Choices.*

In addition to Passport, Kentucky currently has four 1915 C waivers serving various populations within the Medicaid program as outlined below. Everyone currently served in a 1915 C waiver will be included in the 1115 waiver with the exception of those in the Model II waiver. The current 1915 C waivers are:

1. Acquired Brain Injury

   The Acquired Brain Injury (ABI) waiver was developed to serve Kentucky residents age twenty-one (21) to sixty-five (65) who have an acquired brain injury. These individuals receive inpatient services in a nursing facility, nursing facility/brain injury program, or are currently living in the community and have the potential for inpatient services in a nursing facility or nursing facility/brain injury program. Individuals served in the ABI waiver must meet the level of care criteria for placement in a nursing facility and whose services in a nursing facility would qualify for payment under the State Plan for Medical Assistance. The goal of the ABI waiver program is to rehabilitate and reintegrate individuals with an acquired brain injury into the community with the availability of existing community resources when discharged from the ABI waiver program. ABI services are not available to individuals who have

congenital brain injuries. The acquired brain injury waiver has a capacity for and serves 110 unduplicated members and maintains a waiting list of 83 individuals.

2. Home and Community Based (HCB) Waiver

   The Home and Community Based (HCB) waiver program was developed to serve Kentucky residents who are aged or disabled as an alternative to placement in a nursing facility. Individuals served by HCB must meet the level of care criteria for placement in a nursing facility and whose services in a nursing facility would qualify for payment under the State Plan for Medical Assistance. Any individual who is inpatient at a hospital, nursing facility or Intermediate Care Facility for the Mentally Retarded (ICF/MR), or who is enrolled in another Medicaid waiver or Medicaid-covered Hospice Program is excluded from eligibility. HCB has a total capacity of 17,050 unduplicated members and currently serves 11,598; HCB does not maintain a waiting list.

3. Supports for Community Living (SCL) Waiver

   The Supports for Community Living (SCL) waiver program was developed to serve Kentucky residents with mental retardation or developmental disability as an alternative to institutional care. These individuals must meet the level of care criteria for placement in an Intermediate Care Facility for the Mentally Retarded (ICF/MR) and whose services in an ICF/MR would qualify for payment under the State Plan for Medical Assistance. This program is designed to allow an individual to remain in or return to the community in the least restrictive setting. SCL services are not available to individuals receiving inpatient services in a hospital, nursing facility or ICF/MR. SCL currently serves 2,651 individuals but maintains a waiting list of 2,556.

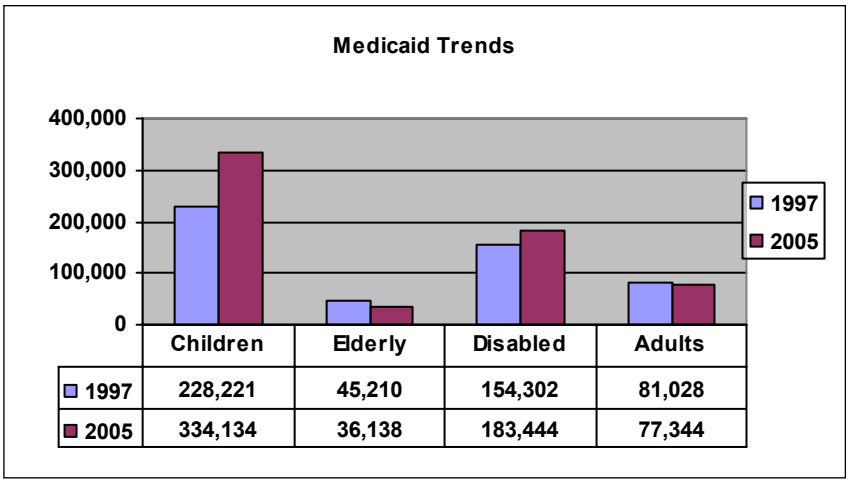
4. Model II Waiver

   The Model II waiver program was developed to serve Kentucky residents who are ventilator dependent as an alternative to hospital-based nursing facility care. These individuals must meet the level of care criteria for placement in a nursing facility and whose services in a nursing facility would qualify for payment under the State Plan for Medical Assistance. Model II waiver services are available to eligible individuals of any age in their homes. The waiver has a capacity of 100 unduplicated members and currently serves approximately 59 individuals. The Model II Waiver will not be included in *KyHealth Choices.*

Future Trends:

Kentucky has seen significant growth in the number of Medicaid members over recent years. In fiscal year 1997, there were 531,868 individuals receiving some or all of their healthcare under the Kentucky Medical Assistance Program. By January 2005, that number had risen to 686,925, with an end of fiscal year projection of 691,000. This is a growth rate of 29.92% over eight years. Kentucky's total population during the same period grew by just over 4%.

The number of disabled members has increased every year since 1997, averaging over 3,000 additional members annually. This resulted in an 18.88% between 1997 and 2005.



	Children	Elderly	Disabled	Adults
1997	228,221	45,210	154,302	81,028
2005	334,134	36,138	183,444	77,344

Children receiving services increased by 46.4% during the period, from 228,221 on June 30, 1997 to 334,134 on January 1, 2005. Of particular note is that this growth rate has accelerated over the past four years, growing from almost 259,000 in SFY 2000 to a projected total of more than 345,000 by the end of SFY 2005.

Surprisingly and in contrast to national trends, the aged category has shown a slight decrease over this same period, averaging 1,134 fewer members per year. On June 30, 1997 there were 45,210 aged participants, while on January 1, 2005 there were 36,138.

Also showing a decrease from 1997 to the mid-point of FY 2005 is the adult category, which declined by 4.6%. On June 30, 1997 there were 81,028 individuals receiving coverage as adults. By January 1, 2005 that had fallen to 77,344; however, the trend for this category since FY 2000 has been upward. There were 58,395 adult participants on June 30, 2000, which has increased each year to the current 77,344.

Kentucky is a Social Security Act Section 1634 (a) state. One consequence of this is that Supplemental Security Income (SSI) beneficiaries are automatically deemed as eligible for Kentucky Medicaid. This has a significant impact on this state's Medicaid program since Kentucky has one of the nation's highest per

capita disability rates. As such, a disproportionate number of Medicaid beneficiaries are eligible due to approval of their disability claim and award of SSI benefits.

Recent Changes to the Infrastructure

In order to prepare the foundation for the major transformation identified in *KyHealth Choices,* significant changes to the Kentucky Medicaid infrastructure must occur. The Cabinet for Health and Family Services and the Department for Medicaid Services (DMS) have spent the last several months ensuring that essential programmatic and policy procedures and capabilities have been created. Some of the changes are already in place while others are beginning implementation. The new and on-going developments to the infrastructure include the following:

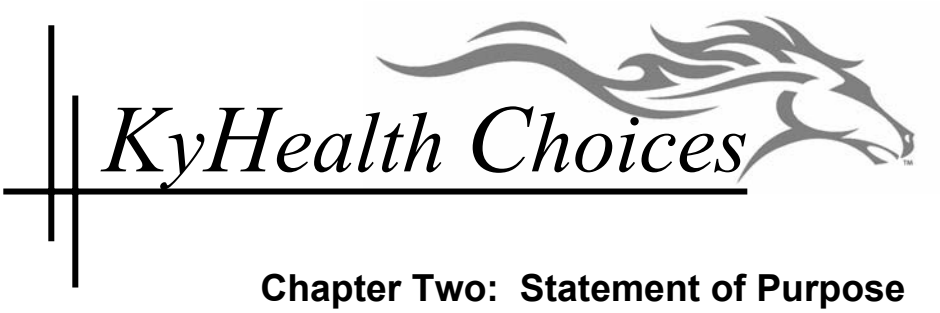
- **Improve the MMIS (Medical Management Information System).**
  - Work with the new MMIS vendor to implement state of the art systems to allow reforms
  - Develop MITA (Medical Information Technology Architecture) aligned architecture
  - Implement client server technology

- **Utilize the Pharmacy Benefit Administrator (PBA) (First Health Services) to administer the pharmacy benefit for Medicaid members.**
  - The PBA will be responsible for:
    - Prior authorization
    - Pharmacy claims payment
    - Clinical criteria
    - Provider education and communications
    - Prospective drug review edits
    - Drug regimen review
    - Rebate management

- **Utilize the Kentucky Medicaid Administrative Agent (KMAA) to administer activities and policies established by the Commonwealth.**
  - The KMAA will develop and/or maintain:
    - Appropriate utilization management systems
    - Clinical review criteria
    - Practice guidelines for Disease Management Programs
    - Benefit packages
    - Care and Disease Management Programs
      - Examples:
        - Asthma Care Choices
        - Diabetes Care Choices
    - Tools and protocols for identifying and assisting members with special health care needs

  - Quality management systems
  - Provider relations management capability
  - Member relations management capability

- **Utilize the KMAA to work with the Commonwealth to manage the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program, which will be renamed the "Children's Health & Prevention Program."**
  - Under existing state authority the KMAA will ensure that all T (treatment) services are medically necessary



Chapter Two: Statement of Purpose

The current Kentucky Medicaid system is costly, inefficient and not capable of meeting members' needs and must undergo a sweeping and comprehensive, transformation of the daily operations and relationships of the program. *KyHealth Choices* will demonstrate a model that will accomplish this transformation without a drastic reduction in eligibility or services to those in need.

KyHealth Choices will conduct a major programmatic transformation to improve the health status of those Kentuckians enrolled in the state's Medicaid program. The transformation, detailed in this 1115 waiver application, will ensure a continuum of care and individual choice while securing the solvency of Medicaid for future generations of Kentuckians.

During the development of *KyHealth Choices,* the state focused primarily on four guiding principles: quality and prevention, consumer empowerment and choice, personal responsibility, and community solutions. Additionally, various components and strategies within the waiver are structured around two major goals: stretch resources to more appropriately meet the needs of those enrolled in the Medicaid program and encourage Medicaid members to be personally responsible for their own health care. To accomplish these goals, the Commonwealth is committed to offering its Medicaid members a comprehensive array of options designed to deliver the services they need in the most efficient manner possible. Kentucky is also dedicated to ensuring that the services provided for members are of the highest quality and grounded in evidence based practices. Members will be encouraged to be involved in their own personal health care and prevention, and disease management and wellness programs will be emphasized.

Purpose

Transform the Kentucky Medicaid program by:

- ✓ *Improving the health status of those Kentuckians enrolled in the program;*
- ✓ *Ensuring a continuum of care;*
- ✓ *Guaranteeing individual choice;*
- ✓ *Ensuring the solvency of Kentucky Medicaid for future generations of Kentuckians*

In order to implement the strategies that will achieve these goals, the Commonwealth seeks a demonstration waiver under section 1115 of the Social Security Act. All components of this demonstration waiver will be included in the

state's Title XIX program and will be called *KyHealth Choices.* This waiver will be administered by the Kentucky Department for Medicaid Services, Cabinet for Health and Family Services.

KyHealth Choices will offer six fundamental elements:

1. Benefit Packages: Tailored benefit packages for specific populations will be provided to those enrolled in the Medicaid program. A total of four packages have been developed and will include services to meet basic medical and rehabilitative needs. In addition, benefit packages for those in need of long term care will increase the array of community based services. The long term care packages will include various levels of care where services will intensify based on the level of need. A specific package, Family Choices, has been created to better serve children.

2. Cost Sharing and Service Limitations: Most members enrolled in *KyHealth Choices* will be required to share in the cost of many of the covered services. Co-payments and premiums will be incorporated throughout most of the plans; however, to encourage wellness and decrease dependence on acute services, preventive services will not require a co-pay. Preventive services include, but are not limited to, annual check-ups, vaccinations and pap smears. When a co-payment or coinsurance is required as part of the plan benefit structure, the provider will be responsible for collecting payment from individuals. Limitations on some services have also been included in the waiver. However, all limitations are subject to be set aside based on medical need and approval by the Department for Medicaid Services.

3. Health Insurance Purchasing Program (HIPP): *KyHealth Choices* will also ensure that Kentucky Medicaid is the payor of last resort by establishing a program for members who have access to private insurance coverage to require them enroll in that coverage. *KyHealth Choices* will pay private insurance premiums and wrap around the commercial coverage with Medicaid services.

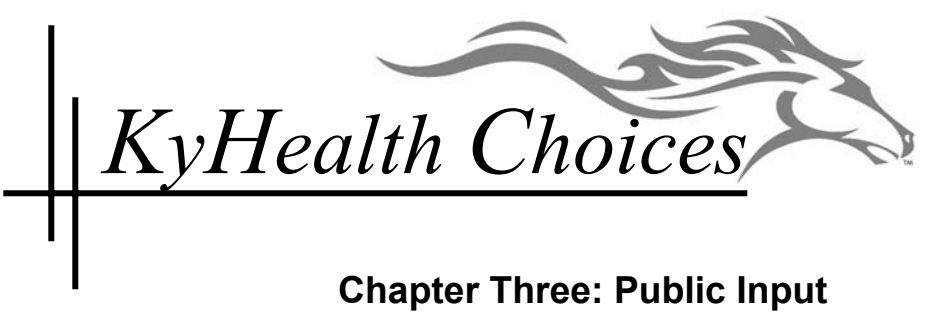
4. Integrated Care: Part of Kentucky's vision of a transformed Kentucky Medicaid program includes the provision of care that is better integrated. Recipients will realize improved coordination of mental health, mental retardation/developmental disabilities, substance abuse and physical health services. The Kentucky Medicaid infrastructure will be improved, using the best practice standards demonstrated in the commercial insurance market as its model, allowing for both cost-savings and improved healthcare delivery system practices.

5. Disease Management Programs**:** *KyHealth Choices* will develop disease management programs throughout the state to assist those with chronic

illnesses such as pulmonary disease, cardiovascular disease, pediatric obesity and diabetes. Services will include assessments and educational information about the disease and treatment. Disease Management services have already been contracted through the KMAA.

6. Get Healthy Accounts: Get Healthy Accounts will be established to provide incentives to Medicaid members for healthy behaviors. Initially, disease conditions for participation in this program will be limited to pulmonary disease, diabetes and cardiac conditions, however, additions may be added later. The Commonwealth will identify specific activities that will be eligible for incentives and will set values for each eligible activity. As members earn access to these incentives, funds will be deposited into their accounts. The member may use the funds to offset health care related costs, such as co-pays, alternative therapies, exercise, weight loss or smoking cessation programs.

KyHealth Choices will provide healthcare coverage for Medicaid members throughout the state excluding those in currently under the Passport waiver, Qualified Medicare Beneficiaries (QMBs), Specified Low Income Medicare Beneficiaries (SLMBs), Qualifying Individuals (QI1) Qualified Disabled Working Individuals (QDWIs) and the ventilator-dependent individuals served under the 1915 C Model Two II waiver. All other members of every health category and disability category will be part of *KyHealth Choices.* Current 1915C waivers for acquired brain injury, supports for community living and home and community based services will be grandfathered in to *KyHealth Choices.*



Chapter Three: Public Input

The Cabinet for Health and Family Services values the unique expertise that can only be found through the individuals served, their families, advocates and community service providers. Prior to the actual drafting of *KyHealth Choices,* the Cabinet spent several months gathering information from the stakeholder community. The Undersecretary of the Cabinet and the Commissioners of the Departments for Mental Health and Mental Retardation and Medicaid Services met at least weekly, either jointly or separately, with various groups across the state to discuss issues and concerns regarding the Kentucky Medicaid program.

In addition, the Cabinet developed a strong relationship with a large coalition of advocacy organizations. Advocates for Reforming Medicaid Services (ARMS) representatives meet monthly with Cabinet officials to discuss updates and continuing needs within the program. The Cabinet has also utilized meetings with various statewide commissions, such as the Commission on Services and Supports for Individuals with Mental Retardation and Other Developmental Disabilities (HB 144) and the Kentucky Commission on Services and Supports for Individuals with Mental Illness, Alcohol and Other Drug Abuse Disorders, and Dual Diagnosis (HB 843) to gather additional input.

> *"I believe that every right implies a responsibility; every opportunity, an obligation; every possession, a duty."*
>
> *John D. Rockefeller, Jr.*

During the actual development of the waiver, Cabinet staff met repeatedly with the membership of ARMS and a newly formed coalition, the Medicaid Consortium. Both groups are comprised of numerous advocacy organizations representing the poor, children, aged and individuals with disabilities. Human service providers and lobbyists are also members of ARMs and the Consortium. Moreover, the Cabinet has discussed ideas and alternatives with key legislators, the Kentucky General Assembly's Joint Committee on Health and Welfare and various experts in the Medicaid field.

The Cabinet made a concerted effort to seek assistance and input from the advocacy and provider community by creating a Medicaid waiver team to draft the initial waiver proposal. The team, comprised of four representatives each

from ARMs and the Medicaid Consortium, as well as lead staff from the Departments of Medicaid and Mental Health and Mental Retardation Services, literally entered into “Waiver Boot Camp.”

The waiver team met every other day for three weeks to draft out the many and varied details for the waiver proposal. In between meetings, the representatives were responsible for communicating with the various organizations and constituencies they represent to ensure adequate updates to the community and ongoing input into the planning and drafting process. In addition, the Cabinet sought assistance from the Supports for Community Living (SCL) workgroup represented by the provider associations to ensure effectiveness and efficiency in rolling the 1915 waivers into *KyHealth Choices.*

Chapter Four: Demonstration Design

KyHealth Choices is comprised of an array of key components with each component contributing to a comprehensive, consumer-centric continuum of care that is fiscally sound. The components are identified under two major goals as determined by the administration and other key stakeholders from throughout the state. The design of *KyHealth Choices* is based on these goals.

Goal One

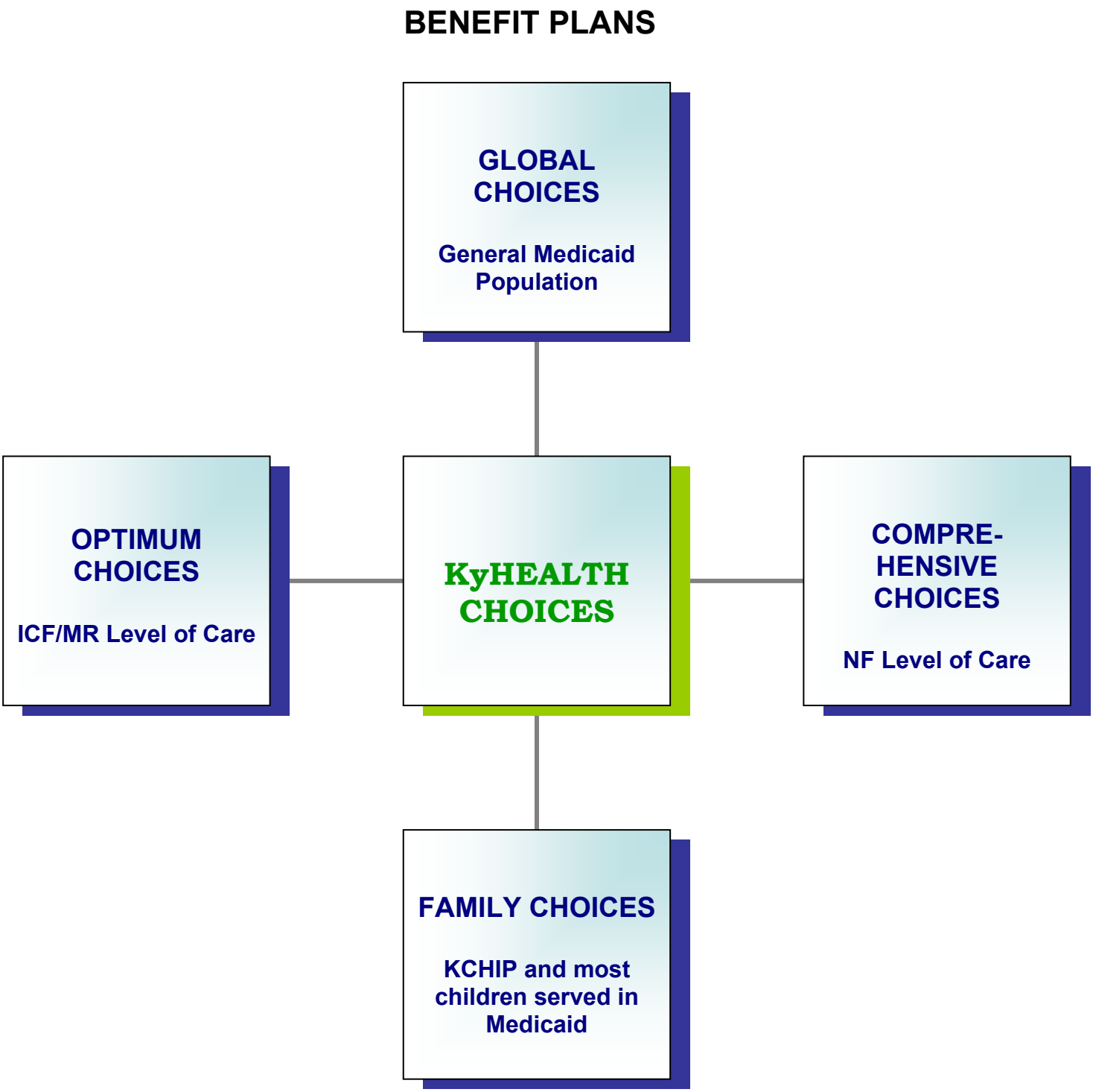
Stretch resources to most appropriately meet the needs of members

Considering the number of members and the amount of money expended on their healthcare, it is imperative that services are provided in the most efficient and cost-effective manner possible. This premise is true despite constraints beyond our state's control. For example, Kentucky's Medicaid benefit package must, under current federal policy, be the same for all populations, regardless of medical condition or need. In addition, there are no financial incentives for our Medicaid members to conserve their use of services to those medically necessary or to seek services in the most cost-effective venue. These issues, along with federal cost containment initiatives, have left the Commonwealth with a $425 million deficit that must be addressed. While *KyHealth Choices* will not address Kentucky's FY05-06 Medicaid budget deficit, it will transform the program to prevent future budget imbalances and ensure long term solvency.

I. Varying Benefit Packages

To accomplish Goal One, *KyHealth Choices* must establish a variety of benefit plans to ensure quality healthcare coverage for its members. Coverage types will be based upon financial and categorical eligibility and will include, at a minimum, a standard benefit package for the Kentucky Medicaid program. The packages will allow for the offering of optional services targeted toward specific populations. Many disabled and long-term unemployed individuals will continue to receive care on a fee-for-service basis. In addition, special packages will be developed to ensure appropriate care for those who need long-term care. For

some plans, cost sharing in the form of co-payments and/or coinsurance, as well as premiums will be required on a sliding fee scale based on income. The following diagram illustrates the four benefit packages which will be offered in the *KyHealth Choices* waiver.



Global Choices is the standard package provided for most Medicaid members and is the benchmark to which the other plans are compared. This plan provides basic medical services, including mental health services in inpatient and outpatient settings. Hearing and vision services will be limited to those 18 and under unless the service is Early Periodic Screening Diagnosis and Treatment (EPSDT) related in which case it will be offered until the member reaches age 21.

Two packages have been developed for those members needing long-term care services. The **Comprehensive Choices** plan will include all benefits in Global Choices and it will cover individuals who need a nursing facility (NF) level of care, are at risk of institutionalization and/or have been previously covered under the HCB Waiver or the ABI waiver. The plan will include NF level of care services and all services currently available under the current ABI and HCB waivers and nursing facility services. The 83 individuals on the ABI waiting list will be rolled into Comprehensive Choices upon start-up.

Optimum Choices will cover disabled adults in need of ICF/MR level of care, are at risk of institutionalization and/or are currently being served in the SCL waiver. The plan will include all benefits in Global Choices and it will include ICF/MR level of care appropriate services such as all services under the current SCL waiver and the ICF/MR services. Optimum Choices will also include a new level lower level of services aimed at keeping people in their homes longer. This level of care will replicate the service package available in the HCB waiver and will be in place by July 1, 2006. A waiting list will remain for the SCL services for this population.

The **Family Choices** package is designed for children and will serve those currently covered by the KCHIP program and some children currently served under the traditional Medicaid program. During Phase II of the waiver, the plan may be expanded to serve uninsured low-income parents of KCHIP children.

All benefit packages included in *KyHealth Choices* will be structured to assure a continuum of care to maximize the use of services provided in an individual's home. The standard package for *KyHealth Choices* will cover many important healthcare services, including doctor visits, hospital stays, habilitation, therapeutic, and behavioral health services. Medicaid services will be provided as they are today. Mental Health parity will be common to all benefit packages.

II. Eligibility Coverage

Many of the key elements of the revised eligibility process will have the most significant impact on the long-term care population and the working poor. Revised eligibility requirements include an increase in counting income to ensure co-pays and premiums, an obligation to purchase available cost effective

insurance, an increase in consumer-directed options and the ability to purchase limited services as needed in long-term care.

III. Covered Service Limitations

In order to provide additional or special services to the targeted populations, the *KyHealth Choices* benefit packages may vary the amount, duration and/or scope of certain services and may contain service-specific coverage limits, such as the number of visits or dollar cost. None of the visit or dollar cost limits are "hard" limits; they are "soft" limits, enabling additional visits or services beyond the stated limit may be approved if medical necessity is demonstrated by a member's provider.

All of the *KyHealth Choices* benefit packages contain a prescription drug limit of four drugs per month with a maximum of three of those drugs being brand drugs; however, this limit is also a "soft" limit and can be overridden when medical necessity is demonstrated. Additionally, these prescription limits will not apply to members who have been diagnosed with certain chronic conditions, including but not limited to:

- High blood pressure & Type II diabetes at the same time
- Alzheimer's Disease
- Cancer
- End Stage Lung Disease
- End Stage Renal Disease (ESRD)
- Terminal Stage of an Illness
- Hemophilia
- HIV/AIDS
- Migraine Headaches
- Epilepsy
- Thyroid Cancer
- Heart Disease
- High Cholesterol
- Metabolic Syndrome
- Organ Transplant
- Diabetes

Additionally, atypical antipsychotic drugs will not count against the three brand maximum.

Limitations may apply to the four benefit packages identified in the *KyHealth Choices* Waiver proposal based on the needs of the identified population and individual needs. For example, the scope and quantity of services to be provided under the Comprehensive and Optimum Choices for individuals with long term care needs will be clearly identified in the member's comprehensive care plan.

Only those services included in the care plan will be reimbursable by *KyHealth Choices*.

Services not covered under Medicaid and identified in the coverage section of the waiver will be the financial responsibility of the member if not funded by another payment source.

Once an individual is Medicare eligible the Commonwealth will only pay the patient liability amount under Medicare for services covered by Medicare. Medicaid's payment shall not exceed the Medicaid allowable amount for that service.

Services related to Autism have been limited to a $500 monthly maximum in an effort to mirror Kentucky managed care requirements for commercial insurance. This will help bridge the gap between private insurance and public assistance programs.

All of the benefit packages will cover mandatory Medicaid services. Any services that are not included in the benefit packages, or that exceed those in a benefit package and have not been prior approved, will be considered non-covered services.

IV. Benefit Grids

State Plan Covered Services

Mandatory Services
Inpatient Hospital (excluding inpatient services in institutions for mental disease)
Outpatient Hospital (including FQHCs) and rural health clinics
Laboratory and x-ray
Certified pediatric and family nurse practitioners
Nursing facility services for beneficiaries age 21 and older
EPSDT services for children under age 21
Family planning services and supplies
Physicians' services
Medical and surgical services of a dentist
Home health services for beneficiaries who are entitled to nursing facility services
Nurse mid-wife services
Pregnancy-related services and service for other conditions that might complicate pregnancy
Durable Medical Equipment
60 days postpartum pregnancy related services

Optional Services
Chiropractic Services
Podiatry Services
Vision Services
Private Duty Nursing
Home Health Care Services
Dental Services
Physical Therapy
Occupational Therapy
Therapies for Speech, Hearing, and Language Disorders
Prescribed Drugs
Prosthetic Devices
Eyeglasses
Diagnostic Services
Screening Services
Preventive Services
Mental Health Rehab/Stabilization
Inpatient Hospital/Nursing Facility/ICF Services 65 and Older in IMD
ICF/MR
Inpatient Psychiatric Services – Under Age 21
Personal Care Services
Targeted Case Management
Primary Care Case Management
Hospice
Respiratory Care for Ventilator Dependent
Transportation Services
Nursing Facility Services – Under Age 21
Critical Access Hospital

Global Choices Cost Sharing & Limits*						
Benefit/Service	State Plan	Pregnant Women	SSI-Related & Caretaker Relatives	BCCTP	Hospice (non-institutional)	Foster & Federally-Subsidized Adopted Children
Medical Out-of-Pocket Maximum	No Maximum	N/A	$225 per 12 months	$225 per 12 months	$225 per 12 months	N/A
Pharmacy Out-of-Pocket Maximum	No Maximum	N/A	$225 per 12 months	$225 per 12 months	$225 per 12 months	N/A
Acute Inpatient Hospital Services	$50 per admission	None	$20	$50	$30	None
Diagnostic Services	$0	None	$3	$10	$8	None
Radiology Services	$0	None	$2	$10	$7	None
		Limit to 12 occasions per pregnancy	Limit to 12 occasions per 12 months	Limit to 12 occasions per 12 months	Limit to 12 occasions per 12 months	Limit to 12 occasions per 12 months
		Limit 1 Ultrasound per pregnancy				
Outpatient Hospital/Ambulatory Surgical Centers	$3	None	$8	$20	$16	None
Provider's Office Services**	$2	None	$2	$10	$8	None
Preventive Services	$0	None	None	None	None	None
Emergency Ambulance	$0	None	None	None	None	None

Dental Services • Preventive • Extractions	$2	None $4	None $4	None $4	None $4	None None
		2 cleanings per 12 months 1 x-ray per 12 months	2 cleanings per 12 months 1 x-ray per 12 months	2 cleanings per 12 months 1 x-ray per 12 months	2 cleanings per 12 months 1 x-ray per 12 months	2 cleanings per 12 months 1 x-ray per 12 months
Family Planning	$0	None	None	None	None	None
Occupational Therapy	$0	None	$2	$2	$2	None
			15 visits per 12 months	15 visits per 12 months	15 visits per 12 months	15 visits per 12 months
Physical Therapy	$0	None	$2	$2	$2	None
			15 visits per 12 months	15 visits per 12 months	15 visits per 12 months	15 visits per 12 months
Speech Therapy	$0	None	$2	$2	$2	None
			10 visits per 12 months	10 visits per 12 months	10 visits per 12 months	10 visits per 12 months
Hospice (non-institutional)	Covered same as the Medicare Program	Covered same as the Medicare Program	Covered same as the Medicare Program	Covered same as the Medicare Program	Covered same as the Medicare Program	Covered same as the Medicare Program
Non-Emergency Transportation	Not Covered	None	None	Not Covered	None	None
Chiropractic Services	$2	Not Covered	$2	Not Covered	Not Covered	None
			7 visits per 12 months for children > 15 visits per 12 months for adults 21 and over			7 visits per 12 months

Prescription Drugs	$1 1st Tier $2 2nd Tier $3 3rd Tier Optional eligibility categories $3 1st tier $10 2nd tier $20 3rd tier	$1 generic $2 pre-ferred brand $3 non-preferred brand	$5 generic $10 preferred brand $15 non-preferred brand	$5 generic $10 preferred brand $15 non-preferred brand	$1 generic $2 preferred brand $3 non-preferred brand	None
		Limit of 4 prescriptions per month; maximum of 3 brand	Limit of 4 prescriptions per month; maximum of 3 brand	Limit of 4 prescriptions per month; maximum of 3 brand	Limit of 4 prescriptions per month; maximum of 3 brand	
Emergency Room	$3 for non-emergent visits	None	$30 for non-emergency visits ONLY Copay waived if admitted	$30 for non-emergency visits ONLY Copay waived if admitted	$30 for non-emergency visits ONLY Copay waived if admitted	None
			Limit 8 visits per 12 months	Limit 8 visits per 12 months	Limit 8 visits per 12 months	
Autism • Rehabilitative and Therapeutic Care Services • Respite Care for children ages two through 21	$0	None	None	Not Covered	Not Covered	None
			$500 maximum per month			$500 maximum per month

Hearing Aids	$2	None	None $1,400 maximum per ear every 36 months; children under 21 ONLY	Not Covered	Not Covered	None $1,400 maximum per ear every 36 months; children under 21 ONLY
Audiometric Services	$2	None	None 1 visit per 12 months; children under 21 ONLY	Not Covered	Not Covered	None 1 visit per 12 months; children under 21 ONLY
Vision Services	General ophthalmology and optometry $2	None $400 maximum on eyewear per 12 months; children under 21 ONLY	None $400 maximum on eyewear per 12 months; children under 21 ONLY	Not Covered	Not Covered	None $400 maximum on eyewear per 12 months; children under 21 ONLY
Prosthetic Devices	$0	None	None	None	None	None
Cardiac Rehab Therapy	$0	None 20 visits per 12 months	None 20 visits per 12 months	None 20 visits per 12 months	None 20 visits per 12 months	None 20 visits per 12 months
Home Health Services	$0	None 30 visits per 12 months	None 60 visits per 12 months	None 30 visits per 12 months	None 30 visits per 12 months	None 30 visits per 12 months
Skilled Nursing Facility	$0	None 30 days per 12 months	None 15 days per 12 months	None 30 days per 12 months	None 30 days per 12 months	None 30 days per 12 months

Durable Medical Equipment	$0	None	2% coinsurance up to maximum of $20 monthly	5% coinsurance up to maximum of $30 monthly	5% coinsurance up to maximum of $30 monthly	None
End Stage Renal Disease and Transplants	$0	None	None	None	None	None
Substance Abuse	Not covered other than EPSDT and Pregnant women	None	None EPSDT only	Not Covered	Not Covered	None EPSDT only

* QDWI's will continue to receive Medicare Part A premium assistance. SLMB's and QI1's will continue to receive Medicare Part B premium assistance. QMB's will continue to receive Medicare Part B premium assistance, payment for co-payments, and payment for deductibles.
** Providers include physicians, nurse practitioners, nurse midwives, FHQCs, and RHCs.

Comprehensive Choices Cost Sharing & Limits		
Benefit/Service	State Plan	NF Level of Care (including ABI)
Medical Out-of-Pocket Maximum	No Maximum	$225 per 12 months
Pharmacy Out-of-Pocket Maximum	No Maximum	$225 per 12 months
Acute Inpatient Hospital Services	$50 per admission	None
Diagnostic Services	$0	None
Radiology Services	$0	None
		Limit to 12 occasions per 12 months
Outpatient Hospital/Ambulatory Surgical Centers	$3	None
Provider's Office Services*	$2	None
Mental Health Office Services (CMHCs)	$0	None
Preventive Services	$0	None
Emergency Ambulance	$0	None
Dental Services • Preventive • Extractions Only	$2	None
		2 cleanings per 12 months 1 x-ray per 12 months
Family Planning	$0	None
Occupational Therapy	$0	None
		15 visits per 12 months

Physical Therapy	$0	None 15 visits per 12 months
Speech Therapy	$0	None 10 visits per 12 months
Non-Emergency Transportation	Not Covered	None
Chiropractic Services	$2	None 7 visits per 12 months for children under the age of 18 15 visits per 12 months for adults 18 and over
Prescription Drugs	$1 1st Tier $2 2nd Tier $3 3rd Tier Optional eligibility categories $3 1st tier $10 2nd tier $20 3rd tier	For members who do NOT have Medicare Part D, $1 generic $2 preferred brand $8 non-preferred brand Limit of 4 prescriptions per month; maximum of 3 brand
Emergency Room	$3 for non-emergent visits	$10 for non-emergent visits
Hearing Aids	$0	None $1,400 maximum per ear every 36 months; children under 21 ONLY
Audiometric Services	$2	None 1 audiologist visit per 12 months
Vision Services	General ophthalmology and optometry $2	None $400 maximum on eyewear per 12 months; children under 21 ONLY

Prosthetic Devices	$0	None
Cardiac Rehab Therapy	$0	None 20 visits per 12 months
DME	$0	2% coinsurance to maximum of $10 per month (NF residents' DME are included in NF rate)
End Stage Renal Disease and Transplants	$0	None
LONG TERM CARE: BASIC LEVEL Eligibility for LTC services will be determined by the Care Plan		
Assessment and Reassessment	$0	None
Case Management	$0	None
Community Living Services • Attendant/Companion • Homemaking • Shopping	No limit $0 $0 $0	None Limit of 40 hours per week
Minor Home Adaptation	$0 Not covered other than EPSDT and Pregnant women	None $500 per 12 months
Adult Day Health Services **OR** Adult Day Social Services	$0	None Limit of 40 hours per week
Skilled Nursing Facility	$0	None 60 days per 12 months or 100 days per 12 months with Medicare
Respite	$0	None Limit of $6,000 per 12 months

Employment Services • Employment Training • Supported Employment	$0	None
		Limit of 40 hours per week. May be used in combination with Adult Day Social, but combined use not to exceed 40 hours per week
Neuro-Rehabilitative Services • Behavior Intervention • Counseling and Training • Substance Abuse Treatment • Neuro-Psych Evaluations	$0	None
		Limit of 10 hours per week Limit of 1 neuro-rehab evaluation per 12 months
LONG-TERM CARE: HIGH INTENSITY LEVEL Eligibility for LTC Services will be determined by the Care Plan		
Nursing Home level of care	$0	None
Institutional Hospice	$0	None
Nursing Facility/ABI	$0	None

* Providers include physicians, nurse practitioners, nurse midwives, FHQCs, and RHCs.

Optimum Choices Cost Sharing & Limits		
Benefit/Service	State Plan	ICF/MR/DD Level of Care
Medical Out-of-Pocket Maximum	No Maximum	$225 per 12 months
Pharmacy Out-of-Pocket Maximum	No Maximum	$225 per 12 months
Acute Inpatient Hospital Services	$50 per admission	None
Diagnostic Services	$0	None
Radiology Services	$0	None
		Limit of 12 occasions per 12 months
Outpatient Hospital/Ambulatory Surgical Centers	$3	$10
Provider's Office Services*	$2	None
Mental Health Office Services (CMHCs)	$0	None
Preventive Services	$0	None
Emergency Ambulance	$0	None
Dental Services** • Preventive • Extractions Only	$2	None
		2 cleanings per 12 months 1 x-ray per 12 months
Family Planning	$0	None
Occupational Therapy	$0	None
		15 visits per 12 months
Physical Therapy	$0	None
		15 visits per 12 months

Speech Therapy	$0	None 10 visits per 12 months
Hospice (non-institutional)	$0	None
Non-Emergency Transportation	Not Covered	None
Chiropractic Services	$2	None 7 visits per 12 months for children under age 21 15 visits per 12 months for adults 21 and over
Prescription Drugs	$1 1st Tier $2 2nd Tier $3 3rd Tier Optional eligibility categories $3 1st tier $10 2nd tier $20 3rd tier	For members who do NOT have Medicare Part D, $1 1st Tier $2 2nd Tier $8 3rd Tier Limit of 4 prescriptions per month; maximum of 3 brand
Emergency Room	$3 for non-emergent visits	$10 for non-emergent visits
Hearing Aids	$0	None $1,400 maximum per ear every 36 months; individuals under 21 years of age only
Audiometric Services	$0 General ophthalmology and optometry $2	None 1 audiologist visit per 12 months; individuals under 21 years of age only

Vision Services	$0	None
		$400 maximum on eyewear per 12 months; children under age 21 only
Prosthetic Devices	$0	None
Cardiac Rehab Therapy	$0	None
		20 visits per 12 months
Durable Medical Equipment	$0	2% coinsurance to maximum of $10 monthly
End Stage Renal Disease and Transplants	$0	None
Hospice (non-institutional)	$0	None
BASIC LEVEL Eligibility for services will be determined by the Care Plan		
Assessment and Reassessment	$0	None
Case Management	$0	None
Community Living Services • Attendant/Companion • Homemaking • Shopping	$0	None
		Limit of 16 hours per day alone or in combination with Adult Day Program.
Minor Home Adaptation	$0	None
		$500 per 12 months
Adult Day Health Services **OR** Adult Day Social Services	$0	None
		Limit of 40 hours per week
Skilled Nursing Facility	$0	None
		60 days per 12 months or 100 days per 12 months with Medicare
Respite	$0	None

		Limit of $10,000 per 12 months
Behavioral Support	$0	Limit of 10 hours for initial functional analysis Limit of 6 hours plan development and training Limit of 2 hours for on-going monitoring
Employment Services • Employment Training • Supported Employment	$0	None Limit of 40 hours per week. May be used in combination with Adult Day Social, but combined use not to exceed 40 hours per week
Psychological Services	$0	None
TARGETED LEVEL Eligibility for services will be determined by the Care Plan		
Residential Services (Current SCL homes) * Waiting list will be maintained for this level of care	$0	None
HIGH INTENSITY LEVEL Eligibility for services will be determined by the Care Plan		
ICF/MR level of care	$0	None

* Providers include physicians, nurse practitioners, nurse midwives, FHQCs, and RHCs.
** Services to facilitate dental nutrition will continue to be provided

Family Choices Cost Sharing & Limits				
Benefit/Service	State Plan	Children of Caretaker Relatives	Categorically Needy Children	KCHIP Children
Medical Out-of-Pocket Maximum	No Maximum	$225 per 12 months	$225 per 12 months	$225 per 12 months
Pharmacy Out-of-Pocket Maximum	No Maximum	$225 per 12 months	$225 per 12 months	$225 per 12 months
Acute Inpatient Hospital Services	$50 per admission	None	None	None
Diagnostic Services	$0	None	None	None
Radiology Services	$0	None	None	None
Outpatient Hospital/Ambulatory Surgical Centers	$3	None	None	None
Provider's Office Services	$2	None	None	None
Mental Health Office Services (CMHCs)	$0			
Preventive Services	$0	None	None	None
Emergency Ambulance	$0	None	None	None

Dental Services • Preventive • Extractions Only	$2	None	None	None
		2 cleanings per 12 months 1 x-ray per 12 months	2 cleanings per 12 months 1 x-ray per 12 months	2 cleanings per 12 months 1 x-ray per 12 months
Family Planning	$0	None	None	None
Occupational/Physical Therapy	$0	None	None	None
		15 combined visits per 12 months	15 combined visits per 12 months	15 combined visits per 12 months
Speech Therapy	$0	None	None	None
		10 visits per 12 months	10 visits per 12 months	10 visits per 12 months
Hospice (non-institutional)	$0	None	None	None
Non-Emergency Transportation	Not Covered	Not Covered	Not Covered	Not Covered
Chiropractic Services	$2	None	None	None
		7 visits per 12 months	7 visits per 12 months	7 visits per 12 months
Prescription Drugs	$1 1st Tier $2 2nd Tier $3 3rd Tier Optional eligibility categories $3 1st tier	$1 generic $8 preferred $15 brand	$1 generic $8 preferred $15 brand	$1 generic $8 preferred $15 brand
		Limit 4 prescriptions per month; maximum of 3 brand	Limit 4 prescriptions per month; maximum of 3 brand	Limit 4 prescriptions per month; maximum of 3 brand

	$10 2nd tier $20 3rd tier			
Emergency Room	$3 for non-emergent visits	$30 for non-emergency use	$30 for non-emergency use	$30 for non-emergency use
Autism • Rehabilitative and Therapeutic Care Services • Respite Care for children ages two through 21	$0	None	None	None
		$500 maximum per month	$500 maximum per month	$500 maximum per month
Hearing Aids	$0	None	None	None
		$1,400 maximum per ear every 36 months; individuals under 21 years of age	$1,400 maximum per ear every 36 months; individuals under 21 years of age	$1,400 maximum per ear every 36 months; individuals under 21 years of age
Audiometric Services	$0	None	None	None
		1 audiologist visit per 12 months; individuals under 21 years of age	1 audiologist visit per 12 months; individuals under 21 years of age	1 audiologist visit per 12 months; individuals under 21 years of age
Vision Services	General ophthalmology and optometry $2	None	None	None
		$400 maximum on eyewear per 12 months; children under 21 ONLY	$400 maximum on eyewear per 12 months; children under 21 ONLY	$400 maximum on eyewear per 12 months; children under 21 ONLY
Prosthetic Devices	$0	None	None	None
		$1,500 per 12 months	$1,500 per 12 months	$1,500 per 12 months
Home Health Services	$0	None	None	None
		25 visits per 12 months	25 visits per 12 months	25 visits per 12 months

DME	$0	None	None	None
Substance Abuse	$0	None	None	None
		EPSDT only	EPSDT only	EPSDT only

** Providers include physicians, nurse practitioners, nurse midwives, FHQCs, and RHCs.

MEG	Eligibility Group	Eligibility Category	Description
MEG #1 "Global Choices" • SSI-Related • Caretaker Relatives • Women with Breast or Cervical Cancer • Foster & Adopted Children • Pregnant Women	SSI Recipients	A	Aged individuals 65 and over who receive SSI who do not meet NF level of care
		AP	Aged individuals 65 and over who receive SSI and State Supp who do not meet NF level of care
		B	Blind individuals who receive SSI who do not meet NF level of care
		BP	Blind individuals who receive SSI and State Supp who not meet NF level of care
		D	Disabled individuals who receive SSI who do not meet NF level of care
		DC	Disabled children who receive SSI/MSE who do not meet NF level of care
		DP	Disabled individuals who receive SSI and State Supp who do not meet NF level of care
	State Supplementation (SSP) Recipients	FP	Aged individuals 65 and over who receive State Supp who do not meet NF level of care
		GP	Blind individuals who receive State Supp who do not meet NF level of care
		HP	Disabled individuals who receive State Supp who do not meet NF level of care
	Pass Through (deemed SSI or SSP recipients)	F	Aged individuals 65 and over who lost SSI benefits and are now eligible for "Pass through" Medicaid who do not meet NF level of care
		G	Blind individuals who lost SSI benefits and are now eligible for "Pass through" Medicaid who do not meet NF level of care
		H	Disabled individuals who lost SSI benefits and are now

				eligible for “Pass through” Medicaid who do not meet NF level of care
	Caretaker Relatives of children eligible per Section 1931	C		Caretaker Relatives of children who receive KTAP and are deprived due to death, incapacity or absence
		E		Caretaker Relatives of children who do not receive KTAP and are deprived due to death, incapacity or absence
		T		Caretaker Relatives of children who do not receive KTAP and are deprived due to unemployment
		W		Caretaker Relatives of children who receive KTAP and are deprived due to unemployment
	Caretaker Relatives of children who lose eligibility due to increased earnings, time-limited deductions or increased child support	L		Caretaker Relatives of children deprived of parental support due to death, incapacity, or absence who exceed income and/or resource limit
		N		Caretaker Relatives of children deprived of parental support due to employment who exceed income and/or resource limit
	BCCTP	V		Women eligible in the Breast and Cervical Cancer Treatment Program
	Children w/adoption assistance or foster care payments under Title IV-E of the Act	S		Federally subsidized adopted special needs children who receive grants from social services
		X		Foster care children who receive a grant through Title IV-E
		Program Code	**Status Code**	
	Children in foster care family homes or private	P	P3	Children under age 1 w/income < 185% FPL
		P	P2	Children from 1 to under age 6 w/income < 133% FPL
		P	P1	Children from 6 to under age 19 w/income < 100% FPL

	institutions totally or partially dependent upon and supervised by a public or private child care agency	P	P7	Children under age 1 w/income > 185% FPL but < 200% FPL
		P	P5, P6, P7	Children from 1 to under age 6 w/income > 133% FPL < 200% FPL
		P	P5, P6, P7	Children from 6 to under age 19 w/income >100% FPL < 200% FPL
	Presumptive Eligibility	I, PE		Pregnant Women w/income <185% FPL
MEG #2 "Family Choices" – Children w/Caretaker Relatives; Categorically Needy Children; KCHIP Children	Children under age 18 w/Caretaker Relatives eligible per Section 1931	C		Children who receive KTAP and are deprived due to death, incapacity or absence
		E		Children who do not receive KTAP and are deprived due to death, incapacity or absence
		T		Children who do not receive KTAP and are deprived due to unemployment
		W		Children who receive KTAP and are deprived due to unemployment
	Children w/Caretaker Relatives who lose eligibility due to increased earnings, time-limited deductions or increased child support	L		Children deprived of parental support due to death, incapacity, or absence who exceed income and/or resource limit
		N		Children deprived of parental support due to employment who exceed income and/or resource limit
		Program	**Status Code**	

		Code		
	Categorically Needy Children	I	P3	Children under age 1 w/income < 185% FPL
		I	P2	Children from 1 to under age 6 w/income < 133% FPL
		I	P1	Children from 6 to under age 19 w/income < 100% FPL
	KCHIP	I	P7	Children under age 1 w/income > 185% FPL but < 200% FPL
		I	P5, P6, P7	Children from 1 to under age 6 w/income > 133% FPL < 200% FPL
		I	P5, P6, P7	Children from 6 to under age 19 w/income >100% FPL < 200% FPL
MEG #3 "Optimum Choices" – Individuals who meet ICF/MR/DD level of care	Aged individuals who meet level of care for ICF/MR/DD	A		Aged individuals 65 and over who receive SSI who meet ICF/MR/DD level of care
		J		Aged individuals 65 and over who do not receive SSI who meet ICF/MR/DD level of care
	Disabled individuals who meet level of care for ICF/MR/DD	B		Blind individuals who receive SSI who meet ICF/MR/DD level of care
		D		Disabled individuals who receive SSI who meet ICF/MR/DD level of care
		K		Blind individuals who do not receive SSI who meet ICF/MR/DD level of care
		M		Disabled individuals who do not receive SSI who meet ICF/MR/DD level of care
MEG #4 "Comprehensive Choices" – Individuals who meet NF level of care; ABI	Aged individuals who meet NF level of care	A		Individuals 65 and over who receive SSI who meet NF level of care

waiver; Hospice (institutional)		J	Individuals 65 and over who do not receive SSI who meet NF level of care
	Disabled individuals who meet NF level of care, including those served by the ABI waiver	B	Blind individuals who receive SSI who meet NF level of care
		D	Disabled individuals who receive SSI who meet NF level of care
		K	Blind individuals who do not receive SSI who meet NF level of care
		M	Disabled individuals who do not receive SSI who meet NF level of care
	Aged individuals who meet NF level of care and are in hospice	A	Individuals 65 and over who receive SSI who meet NF level of care and are terminally ill
		J	Individuals 65 and over who do not receive SSI who meet NF level of care and are terminally ill
	Disabled individuals who meet NF level of care and are in hospice	B	Blind individuals who receive SSI who meet NF level of care and are terminally ill
		D	Disabled individuals who receive SSI who meet NF level of care and are terminally ill
		K	Blind individuals who do not receive SSI who meet NF level of care and are terminally ill
		M	Disabled individuals who do not receive SSI who meet NF level of care and are terminally ill

Excluded Eligibles
Those served under the Model II Waiver – Ventilator Dependent
Those served under the 1115 Waiver – Managed Care Organization (Passport)

V. Appeals and Grievances

Any member of *KyHealth Choices* may appeal any denial of, or reduction in, services in the comprehensive care plan following the existing Medicaid appeal procedures established through the KMAA.

VI. Providers

Approved Kentucky Medicaid providers will provide all services included in a member's benefit package. Kentucky is currently implementing consumer directed options in the current HCBS, ABI and SCL waivers. This option, discussed in more detail under the long term care section of this proposal, will be continued under the 1115 waiver.

VII. Reimbursement

Services will be reimbursed on a fee-for-service basis, utilizing fee schedules approved by the Cabinet for Health and Family Services and the Department for Medicaid Services. Claims will be submitted and reimbursed by the State's Fiscal Intermediary in accordance with requirements and fee schedules in effect for the program.

VIII. Co-payments

KyHealth Choices will require some members to pay for certain pharmacy and non-pharmacy related services and will be based on income levels.

Co-payments are due to the provider at the time of service, some *KyHealth Choices* members will not have to pay copay for any covered service if the member is:

- Under the age of 19 (except for prescription and emergency room services); or 21 if covered by EPSDT;
- Pregnant women (except for prescription and emergency room services);
- Receiving a Medicare-covered drug at a pharmacy that is a certified provider for Medicare;
- Receiving inpatient services in a nursing facility chronic disease or rehabilitation hospital, or intermediate-care facility for the mentally retarded, or are admitted to a hospital from such a facility;
- Receiving hospice care;
- Has reached the co-payment cap for the year. The co-payment cap for all plans is $225 per individual and $350 per family annually for pharmacy services and $225 per individual and $350 per family annually for all other medical services.

IX. KCHIP Redesign

Under the proposed 1115 waiver, the Kentucky Children's Health Insurance Program (KCHIP) will be redesigned in two distinct phases. Phase I will transform the program from a Medicaid look-alike program to a separate, stand-alone program. The new program services will be modeled after the Commonwealth of Kentucky's 2005 Enhanced Plan (formerly called PPO Option A) with a package(s) tailored toward providing the most applicable services for children.

Eligibility for Family Choices will include children with caretaker relatives, infants whose gross family income is not more than 200% FPL, children ages 1 to under 6 with gross family incomes up to 200% FPL, and children ages 6 to under age 19 to under 200% FPL. Those whose gross family income is greater than 185% FPL but not more than 200% FPL will be required to pay a monthly premium of $20.

In Phase Two *KyHealth Choices* plans to select an insurer to operate the new program on an at-risk basis through a request for proposal (RFP) process on a monthly premium basis, unless the actuarial costs demonstrate that it would be more cost effective to build the infrastructure and administer the program within the Cabinet.

By leveraging the commercial market, KCHIP can tap into comprehensive disease management programs and case management initiatives that are already in place. Disease management vendors heavily court commercial carriers, and carriers receive numerous free educational materials and items such as glucometers that will be distributed to KCHIP recipients. The Department for Medicaid Services is unable to accept these kinds of items.

Using a commercial carrier will also enable KCHIP recipients to receive a membership identification card with the carrier's logo on it rather than a KCHIP card, potentially removing some of the stigma and/or potential barriers to care associated with state assistance programs.

Utilizing the private market will increase access to services. The private market offers more robust provider networks due to their ability to leverage providers, especially as related to areas of practice such as pediatrics and pediatric specialists, for which there is significant need within the KCHIP population.

The possibility may be explored in the future of expanding coverage to uninsured low-income parents and caretakers of children enrolled in Family Choices by allowing these individuals to pay the premium differential for a family

plan and obtain coverage for themselves. It has been demonstrated that there is a greater likelihood that children will stay insured if their parents also have coverage.

X. Long-Term Care Redesign

Kentucky will spend $720 million dollars to serve 24,000 individuals in nursing homes during the current twelve month cycle. Additionally, thirty-eight percent of the entire budget for individuals with mental retardation or other developmental disabilities goes toward the institutional care of only two percent of the population. The *KyHealth Choices* proposed waiver addresses both shortcomings in service availability and in inherent bias in the current funding mechanisms for long term care.

KyHealth Choices will provide adults with mental retardation and other developmental disabilities, acquired brain injuries, physical disabilities and the frail and elderly real choices to receive needed long-term care services in a home and community-based setting without having to wait for a slot in a 1915 C waiver program or to choose a nursing facility or ICF/MR. All individuals currently eligible for Medicaid and in receipt of long-term care services in a nursing facility or in three of Kentucky's current 1915 C waivers (Supports for Community Living, Home and Community Based Services and Acquired Injury) will be enrolled in the waiver.

The primary goals of the long-term care plans are to provide members with an expansion of choices and with equal access to long-term care options (institutional and home- and community-based services with consumer-directed options) and to promote and provide early intervention for at-risk populations. Kentucky intends to accomplish these goals by continuing to build and expand upon its existing home and community based services while continuing to ensure the availability of high quality institutional based services.

The intent of the long-term care components of *KyHealth Choices* is to ensure quality based services for those enrolled in the program and controlling the overall costs for long-term care in the State. It is designed to ensure elders and other adults with physical or mental disabilities can live as independently as possible for as long as possible in the most appropriate setting. The most appropriate setting may be their home, a staffed residence or an institutional facility.

Those individuals currently served under the home- and community-based services and acquired brain injury waivers will be covered under the Comprehensive Choices plan. Those currently served under the Supports for Community Living Waiver will be provided coverage under the Optimum Choices Plan.

Both the Optimum and Comprehensive Choices plans will include various levels of care. The level of care for each member will be determined by individualized plans of care. It is the intent that the plans of care will create a seamless process which will allow an individual to travel back and forth through the levels as their needs change. Optimum Choices will begin Phase I with three levels: Basic, Targeted and High Intensity. During Phase II a fourth level, Intermediate Care, will be added. Comprehensive Choices will begin Phase I with two levels of care: Basic and High Intensity. The plan will be expanded to include an Intermediate Level of Care during Phase II of the waiver. Both plans will include consumer directed options as an alternative to traditional services.

The Basic Level of Care is the first level of care covered under both the Comprehensive and Optimum Choices for the *KyHealth Choices* demonstration waiver. Individuals served by the Basic Care Package will include physically disabled, medical needy and dual eligible adults who meet the Medicaid financial and clinical criteria for long term care. The Basic Level of Care Plan will include a variety of individual service options from which the consumer can choose based on his or her own needs. Individualized plans of care will be created for each member based on person centered planning principles which allow for self directed choices and personal responsibility for each members medical care. Only one service, case management, will be required for Optimum and Comprehensive Choices. However, the amount of case management services will vary based on the comprehensive plans of care.

Those identified as needing a High Intensity Level of Care benefit under the Comprehensive and Optimum Choices will be entitled to either a nursing facility/ABI, nursing facility or ICF/MR. High Intensity Level of Care members will serve physically disabled, medically needy and dual eligible adults who meet Medicaid long-term care eligibility standards.

During Phase I, the Optimum Plan will include a third level of care entitled the Targeted Plan of Care. This plan “targets” those individuals who would benefit from a less restrictive environment than the traditional ICF/MR but may need more care than can be offered by the Basic Plan. The Targeted Plan offers a three person community living component currently offered under the SCL waiver.

The Intermediate Care Package will be added to both the Comprehensive and Optimum Plans during Phase II of the waiver. The Intermediate Level of Care will include unique options including enhanced residential living, home sharing, and other housing and support services.

Members of both the Comprehensive and Optimum Choice plans will be notified of the new plan via written communication and electronic formats no later than December 20, 2005 prior to the planned roll out on January 1, 2006.

XI. Consumer Directed Options

Research has shown that when consumers control their own Medicaid personal assistance services, they are more satisfied with their lives and their support services. For that reason, *KyHealth Choices* will offer Consumer Directed Options (CDO) for those Medicaid recipients who qualify for Optimum and Comprehensive Choices. The CDO for *KyHealth Choices* is initially designed as an alternative to the traditional service delivery model under the long-term care plans for this waiver. *KyHealth Choices* will explore the option of providing CDO to the other plans at a later date.

Design and Goals

The consumer-directed option (CDO) was designed as an alternative to the traditional service delivery model under this waiver. Individuals who elect and are eligible for the CDO may access non-medical and non-residential services via CDO and medical and residential services under the traditional model. The blended package allows consumers to pick and choose the options that best meets their needs. Services provided via the CDO may be cross walked to a service under the traditional service option. This enables consumers to terminate CDO services and seamlessly transition back into the traditional service option with no lapse of service delivery. The goal of the CDO is to increase consumer control and independence while providing greater flexibility in service delivery and increasing consumer satisfaction and quality of life.

Consumer Directed Option Criteria

To participate in consumer-directed service option the individual must meet the eligibility and financial requirements for *KyHealth Choices* waiver program. The individual must have the ability to self-direct their own care and understand the rights, risks and responsibilities of managing their own care with an individual benefit total or if unable to make decisions independently, designate a representative to assist them. The CDO will also be available to consumer's that are a minor child and a legally-responsible parent or legal guardian elects to employ this option.

Individuals or their designated representative are required to sign a MAP 071, Consumer Rights and Responsibilities Form which is included as part of this attachment. The designated representative must be willing to serve in this capacity and understand the rights, risks and responsibilities of managing the care of the participant with an individual benefit total.

The representative shall not be monetarily compensated and shall have no vested interest in any agency that may provide waiver services. The representative must: be at least twenty-one years of age; agree to a predetermined frequency of contact with the individual; be willing to comply with

all criteria and responsibilities of individual; agree to assisting the individual with their benefit total based on the individual's plan of care and support spending plan, and obtain approval from the individual or family to serve in this capacity. The individual or the support broker may request a representative. The designated representative must complete a MAP 070 form, Representative Designation Form, which is included in this attachment. Individuals who are unable to understand the rights, risks and responsibilities of directing their own care with a individual budget or unable to designate a willing representative or individuals who are receiving Medicaid Hospice benefits are not appropriate for participation in the consumer-directed service option.

Support Brokerage

Support brokerage is required for all individuals participating in the consumer-directed services option or who choose to receive a blend of services under the traditional and consumer directed option and is an administrative activity. Functions of support brokerage include providing information regarding alternatives to make informed choice; care planning which includes assisting with the development and revision of the Consumer Directed Option Plan of Care/Support Spending Plan (CDO POC/SSP) utilizing person centered planning process and guiding principles; authorizing services and additional funding if necessary; monitoring the CDO POC/SSP and satisfaction with and quality of service provision; assisting with locating services and negotiating rates; offers practical skills training which includes hiring, training, scheduling and terminating service providers; development of and monitoring of the participant's emergency back up plan which may include arranging for the provision of emergency services if necessary; establishes participant's request for benefit total based on need, utilization and existing service limitations; helps the consumer ensure that his/her rights and safety are protected; evaluates the participant's health and safety needs; conduct quarterly reviews of participant's spending; and completing all necessary paper work. Additionally, activities such as providing technical assistance regarding managing the individual budget and spending and records management to participant's and service providers shall be included under this service. Support brokerage shall be available twenty-four (24) hours per day, seven (7) days per week.

The Support Broker shall perform all the above and all case management activities for individuals receiving a blended package of services under the traditional and CDO models. The support brokerage entity is responsible for interfacing with providers under the traditional service delivery model to ensure a smooth transition if an individual elects and is eligible to move to the consumer directed service option or if the individual is receiving services under both service delivery models. The support brokerage entity must work closely with the financial management provider to ensure payment for service provision is within the scope of the CDO POC/SSP and prior authorization limits. Also, the Support Broker will work closely with the agency conducting the reassessment for

consumers they are providing support brokerage for. The support brokerage entity shall be independent of other service provision.

Assessment/Support Spending Plan Development/Reassessment
During initial implementation and phase in, the State Medicaid Agency will send notification to recipients regarding the CDO. Recipients that are interested in participating in CDO will notify state staff. Individuals currently in 1915 C waivers who are utilizing the CDO option will be grandfathered into the *KyHealth Choices* CDO component. State staff will meet with these individuals and families and assist them with accessing the CDO.

Also, individuals electing the CDO will be assessed at the time of their level of care assessment. As part of the assessment process, waiver participants and/or their representative are provided information to make an informed decision as to the options available to them and how services will be received. A MAP 351 assessment form will be completed for the assessment and reassessment process.

Individuals choosing the CDO will be referred to a Support Broker and will work with the support broker and fiscal agent in order to efficiently manage allocated dollars. The support broker will assist with developing a CDO Plan of Care/Support Spending Plan (POC/SSP) which is included with this attachment. For CDO the full form will be completed to reflect the plan of care and support spending plan.

Individuals choosing only the traditional model of service delivery will be referred to the case manager provider of their choice. The case manager will facilitate the person centered planning meeting and assist the individual and service planning team with the development of the Plan of Care. Sections of the POC/SSP form relevant for traditional services will be completed for service prior authorization and delivery. Case Management functions will continue as they currently are performed for the traditional service delivery model.

Individuals choosing a blend of traditional and consumer directed services will work with the support broker and the provider agency of their choice to develop the POC/SSP. The POC/SSP will be completed in its entirety to reflect the plan of care and support spending plan.

The care planning process will be the same for both the traditional service and consumer directed service models. The development of the consumer's plan of care/support spending plan will be person centered and based on the guiding principles of individual and family involvement and consumer choice and control. The guiding principles are included with this attachment. The process will be individualized, interactive and ongoing to plan, develop, review and evaluate the support services in accordance with the preferences and desired outcomes of the individual/family. The Support Broker will assist with transition to and

coordination in accessing consumer-directed services, traditional waiver services, State Plan services, and community resources.
Reassessment of each individual shall occur at least every twelve (12) months or more frequently should a significant change occur in the consumer's health or living situation and level of need. The information gathered from the reassessment shall be utilized to make the level of care determination, determination of the consumer's ability and desire to continue participation in the consumer directed option, modify the CDO POC/SSP or traditional POC if necessary and evaluate previous support service provision.

Termination from the CDO
The POC/SSP and service provision will be continually monitored by the support broker. Should monitoring activities reflect the consumers' needs are not being met, health and safety is being jeopardized, or funds in the Individualized Budget are not being utilized according to program criteria, the support broker will work with the consumer or the designated representative to resolve the issues.

The support broker shall notify state staff and the provider agency that conducted the assessment/reassessment of identified issues which may result in the recommendation for termination from CDO. The Support Broker shall work with the individual and/or their designated representative to assist in the resolution or develop a prevention plan. State staff will monitor the actions taken by the Support Broker and resulting outcomes to resolve the issue. If the consumer is unable to resolve the issue, unable to develop and implement a prevention plan or unwilling to designate a representative within ninety (90) days of the identification of the issue, the support broker shall submit a MAP-073, Termination form, with the recommendation for termination from the CDO to state staff and the provider agency that conducted the assessment/reassessment. The support broker shall document how the issue was resolved and the consumer's plan for prevention. If a recommendation for termination is being made, the support broker shall document the reason for the recommendation, actions taken to assist the consumer to continue with CDO and their outcomes. The MAP-073 must be signed by the support broker and the consumer and/or their designated representative. The provider agency shall begin to contact the consumer and/or family within one (1) business day of the submission of the MAP-073 to assist them in locating the service providers of their choice. The support broker will continue working with the current CDO service providers until a traditional provider is located and traditional services are being provided to ensure there is no gap in service provision. A Map-073 is attached.

If at any time State staff determine there is imminent danger due to health and safety issues, immediate termination and return to traditional services will occur until such time the issues can be resolved.

State monitoring staff will review all recommendations for termination by each support broker to ensure the appropriateness of the termination

recommendation, compliance with the termination policy and seamless transition for the consumer. State staff will make the final termination decision and send notification to the consumer and/or their designated representative. The notification will include information to allow the consumer to exercise their appeal rights under the State fair hearing rights should they disagree with the termination decision.

Additionally, a consumer may choose to voluntarily terminate their participation in CDO at any time. Should a consumer make this choice, the support broker shall indicated on the MAP-073 the consumer chose to voluntarily terminate their participation in the CDO.

The voluntary termination section of the MAP-073, CDO Termination form, must be signed by the consumer or their designated representative attesting to the decision for voluntary termination from the CDO option. The MAP-073 shall be forwarded to the provider agency that conducted the current level of care assessment (MAP-351) and the State Medicaid Agency or its designee. The provider agency shall contact the consumer and/or family within one (1) business day of receipt of MAP-073 to assist them in locating the service providers of their choice. The support broker will continue working with the current CDO service providers until a provider is located and traditional services are being provided to ensure there is no gap in service provision.

Individual Budgets

The individual benefit total set for consumers already within the waiver will be based upon the support service needs identified in the POC/SSP and actual historical costs (previous year's expenditures) which will be adjusted for any rate changes and the individual utilization rate which reflects the difference between authorized and delivered services. For new consumers or for consumers whose needs change the State will use the traditional person centered care planning process which includes the completion/revision of the MAP-351 and the POC/SSP and set the benefit total based upon historical cost for the service and the statewide utilization rate. In the event a consumer's needs increase and this change results in an increase to the individual benefit total a budget revision will be requested and shall follow the same requirements for approval as the traditional service option for prior authorization. During enrollment and at the time of reassessments, consumers will be informed of this process and will sign the MAP 071 form acknowledging their right to request a change to their CDO Plan of Care/Support Spending Plan (POC/SSP). This will also be included in the Consumer Handbook given to each consumer at the time of enrollment. The consumer will be allowed to utilize unspent resources from their budgets to purchase goods such as microwaves that will reduce the need for personal services. Any additional, unspent funds will be returned to the system for reauthorization during the next budget cycle.

The Individual Budget will be negotiated on a semi-annual basis to support the outcomes identified in the CDO POC/SSP. The budget will be authorized for a six-month period during which time the individual/family will have flexibility to exercise choice and control in utilizing and managing resources authorized to meet the outcomes in their plan. The individual/family will have the ability to transfer funds from a service area/line items within their budget as long as the individual budget area limitations and the total budget amount for the authorized period are not exceeded. If the consumer or family wish to access additional funds or utilize funds to support an outcome not addressed in their current budget, they will need to notify their Support Broker and request a revision of their CDO POC/SSP. The documentation shall provide information regarding the nature of the problem and the specific breakdown of the additional costs. Budget revisions will be based on the consumers needs, but will not be approved in excess of the individual's historical prior authorization and utilization of services unless an exception is requested by the Support Broker and approved by the State Medicaid Agency or its designee. All budget revisions must be approved by the state designated agency prior to purchasing additional supports.

Consumers must approve and sign Individual Budgets and revisions/addendums prior to the support broker submitting them to the state designated entity for prior authorization for approval. They will receive a copy of the budget or addendum, in addition to monthly updates of the expenditures and their remaining account balances from the Financial Management Agency.

The Support Broker will review and monitor the actual expenditures of the individual budget and assist the individual/family in managing authorized funds. The review will be based on a monthly financial report generated and maintained by the Financial Management Agent. The Support Broker will work with those participants who consistently go over or under their six-month budget to determine the cause, to decide whether reassessment is needed, and/or whether the participant needs additional training regarding his/her responsibilities in order to continue in the consumer-directed option.

Financial Management Activities

Financial Management activities will be delivered as an administrative activity and is required for all individuals participating in the consumer directed option. The Financial Management Agency will assist the consumer and/or their designated representative in managing and distributing funds contained in the consumer's individual benefit total and completion of all required state and federal tax and employment forms. Financial management activities include facilitation of the employment and payment of service providers; completing fiscal accounting functions and expenditure reports; withholding federal, state and local taxes from payment to service providers; establish employment packet and FEIN for each employee; ensuring all federal, state and local tax laws are complied with and accurate tax reporting; employment and wage laws are complied with; verifying that payment is made only for services identified and authorized in the

consumer's POC/SSP; maintain an audit trail of disbursement of funds from the consumer's individual benefit total; and develop and maintain Medicaid agreements with each provider employed by the consumer.

Under the CDO option, direct service staff will complete a MAP-074 Medicaid Provider Agreement form and be assigned a Medicaid provider number. These agreements will be processed by the Financial Management Agency and forwarded to the State Medicaid Agency for approval. Approved provider agreements will be maintained on file by Medicaid and the Financial Management Agency. Current provider agencies and any new agencies enrolling as a waiver provider will continue to complete and update the current Medicaid provider agreement and meet certification requirements prior to approval by the State Medicaid agency as a waiver provider.

Quality Assurance/Participant Protections

In order to fulfill the State's obligation to ensure health, welfare and safety of consumers, the State will provide appropriate oversight and monitoring. CDO services will be subject to the same monitoring and quality assurance and improvement requirements as traditional waiver services. The waiver Quality Committee and Quality Improvement Team will examine and evaluate issues surrounding CDO and traditional waiver services.

The State has a viable system in place for risk management and assuring emergency back up and/or emergency response capability in the event providers of service and supports essential to the individual's health and welfare are not available. The consumers CDO POC/SSP will address plans for what will happen if the primary caregiver is unable to perform their role. CDO POC/SSP's that do not include provisions for emergency back-up and/or emergency response capability will not be approved. Emergency back up provisions shall be individualized and may include the use of other family members or friends, may identify a service-providing agency from which hours may be purchased or the use of other generic paid or unpaid community supports. If difficulty is encountered during the implementation of the emergency plan the Support Broker or a representative of their agency shall be available twenty-four hours per day/seven days per week (24/7) to assist in accessing emergency supports. Consumers will be given a 1-800 number to reach the support broker agency in the event this should occur. The Support Broker will monitor monthly whether the back-up plan has been implemented, the number of times it was implemented and how the plan is working. Should an emergency back-up plan compromise the health, safety and welfare of the consumer, the support broker is responsible for working with the consumer to amend as necessary to assure that a feasible plan is in place at all times. The state also has a viable system by which it receives, reviews and acts upon critical events or incidents. KRS 209 of the Kentucky Revised Statutes requires staff or any other person who has reason to believe or actual knowledge that a child or vulnerable adult has been abused,

neglected, or exploited to report immediately upon discovery to the Department for Community Based Services Child and Adult Protective Services Agency. State staff, Support Brokers, consumers, representatives and providers are provided training regarding the requirements of KRS 209. The current Memorandum of Agreement between the Department for Community Based Services (DCBS), the Department for Medicaid Services and the Department for Mental Health/Mental Retardation will be expanded to include reporting and collaborative investigations when incidents of abuse, neglect or exploitation occur under the consumer-directed option. This interdisciplinary approach will include the above State agencies as part of the resolution. Additionally, the State Medicaid staff person will need to make a determination as to whether the abuse, neglect or exploitation was a result of or related to the consumer receiving services under the CDO.

The review of critical incidents also includes review of other incidents relevant to the health and welfare of the consumer. All incidents are required to be reported to the DMS designated administrative agency for the waiver program for review and analysis. State staff review and make a determination if further action is necessary to ensure the health, safety and welfare of the consumer.

Consumer satisfaction is currently monitored under the traditional service delivery option as part of the quality assurance process. The consumer surveys will include components for monitoring of consumer satisfaction under the consumer-directed option. Consumers, family members and caregivers will also be informed of the Medicaid Member Services 1-800 number. This information is provided on the consumer Rights and Responsibilities form and will be included in the Consumer Handbook as well. Contacts from consumers and/or family members will be entered into the HealthPas System and a report will be generated monthly. This report will be reviewed by program staff, Quality Committee and the Quality Improvement Team. Actions deemed necessary after review will be taken for improvement.

Also, the State will require criminal background checks for all direct service staff hired by the consumer. These will be completed at no cost to the consumer. Consumers will be made aware of this at the time of enrollment. Additionally, consumers will be provided with the 1-800 number for reporting abuse, neglect, or exploitation and instructions on self-reporting. Consumers will also be informed of the 1-800 number to check the nurse aid and home health aid abuse registry at the time of enrollment. The Consumer Handbook which compiles the information in this paragraph will be developed and given to the consumer at the time of enrollment.

The Support Broker will provide family/participant training to ensure participants and their support system are aware of how to provide care and conduct other related activities. This training will include orientation to the program and will cover such things as the philosophy/guiding principles of the consumer-directed

service option, consumer rights and responsibilities, participation requirements, how to manage the individual budget, billing and scheduling, how to recruit, interview, hire and fire direct support staff, and training necessary to safely support the individual while providing direct care. The purpose of this is to identify areas where participants may need help in means of self-direction. The purpose is not to make choices for the participant of to force training that is not needed or appropriate.

Monitoring service delivery: The Support Broker, in conjunction with the financial management agent, will monitor service provision and compare with the CDO POC/SSP and individual budget total. The Support Broker will discuss services with the consumer during required site or home visits or more frequently if needed. Any significant deviation from the plan would trigger the Support Broker to discuss with the consumer and their representative his/her condition and the use of services.

Internal Evaluation: DMS will monitor the work of the Support Broker, Financial Management Agency and the overall health and welfare of the participant. The monitoring will include ensuring that staff have training to identify abuse, neglect, or exploitation and other required training identified in the specific provider qualification section. State staff review incident reports daily to identify any issues that require immediate action be taken and incident report data on a monthly basis to identify patterns or trends that need to be addressed.

All plans will be prior authorized by the state designated entity and will be monitored to ensure they are appropriate for the needs identified and benefit total allocated. State staff will conduct at least annual on-site monitoring reviews which include staff and consumer interviews, home visits, record reviews and review of operating procedures. This will continue and be expanded to include review of consumer accounts/funds disbursement against the POC/SSP's. A written report will be generated and corrective actions for any problems identified will be required. Implementation of corrective action plans shall also be monitored.

If it is determined by either the Support Broker or the State Medicaid staff or their designee, that the participant or their representative are not making safe decisions or is having difficulty with CDO, then they may select an agent advocate work with them. The agent advocate shall act independently on behalf of the consumer and not be connected to any of the CDO or traditional service providers. Participants may elect to utilize a volunteer advocate through one of the local advocacy organizations or seek assistance from the State Department of Protection and Advocacy or the Cabinet Office of Ombudsman. The Office of the Ombudsman investigates and resolves consumer complaints and is charged by law to advocate for citizens to ensure they are treated fairly. The Office of the Ombudsman has an evidence driven quality improvement system in place and provides regular cumulative feedback to program administrators. The

Department of Protection and Advocacy is an independent state agency designed to promote and protect the rights of individuals with disabilities. In addition to advocating for individuals, they provide information and training on self advocacy. Staff includes professional advocates and attorneys.

XII. Self Determination

In addition to the CDO project within the waiver demonstration, Kentucky plans to explore the next step in self determination. Kentucky will offer on a pilot basis the ability for individuals with disabilities eligible for long term supports to craft a highly personal budget from their allocation that may include the following services/supports (in addition to any other services covered under this Waiver) as long as they do not exceed the total allocation.

The first year pilot will be limited to 100 individuals in various parts of the state who are adults or in transition years at school. Their individual allocations will be determined based on typical assessments common to all eligible beneficiaries but then discounted by 5%. Individuals and families will be encouraged to save even within these parameters by offering one half of any savings to be used at the end of that year for one-time purchases that advance any of the life goals included in the person's plan. An additional percentage of the savings will be escrowed in a risk pool for participants who may experience difficulty. The following year the beneficiary's allocation will be reduced by 100% of the savings from the previous year.

This demonstration is predicated on increasing safety and health by concentrating on committed long term relationships and community connections as well as on safe and affordable housing when necessary outside the natural home. In addition, this pilot encourages participants to work or engage in self employment in order to further study the ability to lower total costs while increasing the quality of the person's life.

The following provisions are added to the supports a person may purchase providing again that the total budget not exceed the discounted allocation:

- Freely chosen independent brokering assistance (unbiased and competent assistance to plan, organize and support the implementation of this highly personal plan);

- Financial management assistance (assistance with bill paying, taxes and benefits and regular monitoring and reporting to both funding authorities as well as individuals with disabilities/families.) Financial management can be provided by state sponsored fiscal intermediaries, certified financial planners, public accountants or registered banks and credit unions. Individuals may choose to be the employer of record or choose an appropriate entity;

- Room and board supplements to Social Security in order to insure safe and affordable housing
- Up to 5% of the individual allocation to begin a microenterprise/self employment
- Personal transportation costs including vehicle and insurance costs
- Payments directly to employers and/or other community members for training, co-worker support or transportation assistance to and from work
- Mobility and communication technology assistance
- Post secondary school or instruction
- Personal and companion support for residential living in one's own place
- Community participation and support for social integration

XIII. Independent Case Management

Case Management services will be required for members enrolled in the Optimum and Comprehensive Plans. The goal is to eventually have a completely independent case management system. Service units will be determined by the plans of care. The Case Manager will be responsible for intake, assessment and reassessments, eligibility determination and the development and coordination of the individualized plans of care. Caseloads will be capped at 35 per case manager.

XIV. Health Insurance Purchasing Program (HIPP)

Beyond varying benefit packages, the *KyHealth Choices* proposal will implement several other concepts devised to stretch Kentucky Medicaid resources. One such concept is to ensure that Medicaid is the "payor of last resort" by requiring Medicare members to use that benefit coverage before using their Medicaid benefit.

In addition*, KyHealth Choices* will develop mechanisms to strengthen the Health Insurance Purchasing Program (HIPP), the Commonwealth's program that determines whether it is more cost-effective to assist individuals with access to private coverage in purchasing that coverage and using Medicaid to wrap-around those services. Currently HIPP is woefully under utilized serving only fourteen Medicaid members statewide. *KyHealth Choices* will develop a two phased program that will begin by educating eligibility and in-take workers about HIPP. Phase II will eliminate the wrap and allow for potential "opt-out" for private

coverage. Please note, “opt out” will not force anyone out of the program. However, *KyHealth Choices* will identify incentives to encourage members to utilize HIPP when appropriate.

After payment by the primary insurer (including Medicare) Medicaid will pay as the secondary payor up to the allowable amount. This assumes medical necessity has been determined and plan rules have been followed. Secondary payment only pertains to Medicaid covered services.

XV. Integrated Care Delivery

The current mental health/mental retardation delivery system is fragmented with service availability, access, provider networks and fiscal resources varying greatly from region to region. *KyHealth Choices* will streamline the system of care, balance inequities in the system, integrate more closely with physical health and build accountability into the existing structure of regional planning entities.

Pursuant to KRS 210.375-485, Kentucky will utilize the existing 14 regional mental health planning authorities (community mental health/mental retardation centers) found throughout the state to plan and develop a full continuum of care for each region. The foundation for the integrated health care delivery system will begin by developing mechanisms to support and hold accountable the existing regional planning authorities for their statutory responsibility for planning services and monitoring budgets.

Each CMHC will be required to submit annual plans that will include an impact statement and mechanism for increasing an open provider network. Clear standards, monitoring procedures and performance based contracting will be utilized to ensure accountability. While services will differ based on regional needs and utilization patterns, access and quality will be the same across the state. Core MH/MR benefits such as targeted case management, individual and group therapy, mental health rehabilitation and crisis stabilization will be required in every region. Core services will be provided without a member co-pay. However, through this demonstration, Kentucky plans to give the regional planning authorities flexibility to develop programs specific to their region with a focus on integration and collaboration with physical health providers. Flexibility will be allowed to determine co-pays for these additional covered services.

To ensure quality, *KyHealth Choices* will provide financial incentives combined with strict standards and performance measures for each region. For example, if a regional planning authority developed a care proposal with a projected budget of 35 million dollars which would be a “savings” of 3 million dollars over the last budget cycle of 38 million dollars, the “savings” would be split between Medicaid and community health center. The center would be required to utilize the incentivize funding for new programs and could include typically non-Medicaid services.

KyHealth Choices will expand collaboration and the scope of existing planning commissions (HB 843 and HB 144) to assure input from senior state staff and chairs of regional entities but assure that policy decisions and budget planning will be decentralized to ensure local involvement.

In addition, the *KyHealth Choices* will place requirements through contractual agreements to emphasize the coordination with physical health, particularly by targeting co-morbidities and working with the KMAA.

Services for individuals with mental health and substance abuse disorders will move toward a recovery oriented system. The recovery oriented system must function in a way that incorporates cardinal principles and should include certain essential components such as:

- Treatment services
- Crisis intervention
- Rehabilitation
- Case management
- Outreach and Engagement
- Wellness and Prevention
- Consumer and Family Education

In Phase II the Commonwealth will focus on establishing consumer run and consumer provider services as funding is available.

Co-Occurring Mental Health/Substance Abuse Pilot

The current Medicaid system prevents true integration of services for many individuals with MH/MR and SA who have more than one diagnosis. This is especially true for adults with Severe Mental Illness (SMI) and adolescents with Severe Emotional Disabilities (SED), co-occurring substance abuse is a major contributor to poor community adjustment, problem behaviors and increased use of hospital and other higher levels of care. To address this issue, Kentucky will offer on a pilot basis the ability for adolescents with SED and adults with SMI who have a co-occurring substance use disorder to be provided integrated treatment for both disorders.

The first year pilot will be limited to a maximum of 100 adults and 100 adolescents, and will focus on one region of the state. By limiting the pilot to one region, it will be possible to establish necessary infrastructure and program focus that would be necessary to provide effective interventions.

Individuals will be enrolled in the pilot project based on documentation that participants meet SED or SMI criteria and that they have a co-occurring substance use disorder as determined by a comprehensive assessment.

Services to be made available under this demonstration will include:

- Assessment and service planning
- Out-patient individual, group and family therapy services that focus simultaneously on both mental health issues and substance use and abuse issues
- Out-patient group, individual and family interventions that involve psycho-educational approaches that have been shown to be effective in addressing co-occurring disorders

This pilot project is predicated on demonstrating that providing integrated treatment for mental health and substance use disorders will be more effective than treating each disorder separately, and that this holistic approach to addressing disorders that are inextricably intertwined is demonstrably more effective and less costly than traditional parallel treatment approaches. Research evidence has shown that treating mental health and substance abuse separately is less effective for either disorder; SAMHSA has adopted integrated treatment for co-occurring mental illness and substance abuse as one of their "evidence-based practices."

Funding for the services shall be derived from utilizing the current Maintenance or Effort for the Substance Abuse Prevention and Treatment Block Grant to maximize available resources for the delivery of substance abuse treatment services to individuals with co-occurring disorders.

XVI. Provider Education and Accountability

While much is said in today's insurance market about member education, responsibility and accountability, *KyHealth Choices* also acknowledges an equally strong need for education, responsibility and accountability for providers. Through *KyHealth Choices*, mechanisms will be set in place that will ensure Medicaid providers will be educated about evidence based practices. Provider knowledge of best practices will improve the quality of care and lead to more efficient program operation. In addition, providers will increasingly be held to performance-based contracts with clearly-established goals.

XVII. Fraud/ Illegal Sale of Prescription Drugs

The state is seeking to disqualify for one year, *KyHealth Choices* waiver members who have been convicted under state law of fraud against the Kentucky Medicaid program or convicted of the illegal sale of prescription drugs. In the event the member is incarcerated for such a conviction, the state seeks the discretion to apply this disqualification for a period of one year after the completion of the sentence.

Goal Two

Encourage Medicaid members to be personally responsible for their own health care

Kentucky Medicaid recognizes that the individual can and should play a central role in purchasing and planning for he\r own health care services. *KyHealth Choices* members will recognize the role they play in reducing healthcare cost by making more conscientious choices – choices that result in their continued wellness. Members will be assisted by professional staff and will come to rely on Kentucky Medicaid to assure access to quality healthcare options in order to fulfill their wellness goals.

To accomplish Goal Two, *KyHealth Choices* will implement the following objectives:

I. Get Healthy Accounts

One of the more innovative components of *KyHealth Choices* will be to establish Get Healthy Accounts to promote wellness, self-care and health management. This program will provide a direct incentive to enrollees to take an active role in their health and further the consumer driven model as they will have direct control over funds earned. Get Healthy Accounts will be funded through savings from the waiver. The Commonwealth will set aside an aggregate amount to fund enhanced benefits for each enrollee into a Get Healthy Account.

The Get Healthy Account is designed to maintain or improve the individual's health. One an individual undertakes an approved activity, funds will be placed in an account for the member. For purposes of drawing down federal match, the Commonwealth will consider the money spent once it is placed in the member's account. The Commonwealth will establish a process to reconcile and recoup unspent funds, as outlined below. The process will include a return of the federal share of any amounts recouped.

The Commonwealth will establish uniform statewide standards governing administration and access to accounts to ensure consistent and fair application. To ensure efficient and effective operation, the state will establish eligibility and participation requirements that will apply statewide to all enrollees.

Eligibility

All members who have one of the targeted conditions will be eligible to participate in the Get Healthy Account program. DMS will provide information to members and providers regarding these accounts.

In addition, the Commonwealth will establish a list of activities that will generate contributions to the account. A menu of benefits or programs will be provided as will the individual value of each item on the menu. Members must earn eligibility to access the accounts by exercising personal responsibility and participating in established healthy practices. Therefore, the amount available to individuals from the account will depend on the activities in which they participate up to a maximum amount. The member will be considered an active participant of the program once an approved activity is completed.

Get Healthy Accounts will be available to individuals even after Medicaid eligibility has ended. If an enrollee has funds in the Get Healthy Accounts when eligibility ends, the enrollee may still use funds in the account to purchase insurance such as employee-sponsored insurance, COBRA or private insurance. Individuals with incomes less than 200 percent of the FPL would retain access to funds for up to three years after a loss of eligibility. If a member subsequently regains Medicaid eligibility, the Get Healthy Account will continue and earn additional funds.

Policies

DMS will develop policies and procedures that govern the Get Healthy Accounts. Eligible uses of the Get Healthy Accounts will include qualified health-related expenditures which may include participation in a disease management program relevant to the targeted disease, kept appointments, prevention activities, and filling and re-filling medication in a timely manner.

The Commonwealth intends to work with a variety of private sector partners to develop and participate in these initiatives. Positive health outcomes will be documented by physicians and submitted to the Commonwealth where Get Healthy points will be entered into the member's account. The members may then access the accounts to purchase additional health care services or assist in cost-sharing requirements.

Perhaps the most exciting use of the Get Healthy Accounts will be to participate in such wellness activities as smoking cessation, weight loss programs or other traditionally non-Medicaid covered therapies and programs. In addition, Get Health Accounts may be used to purchase approved wellness or healthy products from vendors such as grocery or drug stores.

II. Education

KyHealth Choices will assure education and to all Medicaid members in an effort to assist them in making the best choice of a benefit package. An educated consumer is more able to make informed choice regarding health care decisions. A series of educational programs will be directed at providing individuals and their families with complete, unbiased information on the various benefit plans, eligibility and the type of services available in their community. In addition,

Kentucky Medicaid will employ various media to provide outreach and education statewide with respect to the transformation of Kentucky Medicaid and *KyHealth Choices*. Outreach efforts will be targeted to current and potential members and healthcare professionals across the state. Consumer directed options will be discussed as a component of the plans. Educational outreach will include the following components:

- Client Education (benefits packages, new eligibility regulations, enrollment/ disenrollment, new cost-sharing requirements, etc.);
- Provider Education (benefit packages of programs, cost-sharing, payment systems, information systems, etc.);
- Managed Care Plan Education (all of the above plus new capitation rate setting, access issues, etc.);
- Staff Education (Kentucky Medicaid staff, other agencies involved in *KyHealth Choices*);
- General Public Education (Health education, outreach, media, etc.).

Additional needs for public education will be assessed and a plan developed by the waiver team, utilizing extensive public input through an open meeting process throughout the state.

III. Choice Counseling

Consumer Directed Option
Members in the *KyHealth Choices* will be provided with choice counseling to aide them in determining if they wish to participate in the Consumer Directed Option program (CDO) for Optimum and Comprehensive Choices.

"Opt-Out" Option
In addition, choice counseling will be provided during Phase II of the waiver to ensure eligible members can make a fully qualified decision regarding their option to voluntarily "opt-out" of Medicaid.

Choice counseling in both programs will provide information to individuals interested in either program, explain the concepts and provide contact information. Choice Counseling will be administered through an independent contractor.

IV. Disease and Care Management

KyHealth Choices will develop disease management programs to assist those with chronic illnesses such as asthma, diabetes, depression and heart disease. Services provided in the disease management program will include telephone contact, an assessment of current health status, educational information about the disease and treatment and the coordination of services through close contact with physicians.

V. Aging and Disability Resource Grant (ADRC)

Kentucky was recently awarded an Aging and Disability Resource Center (ADRC) grant from CMS and the Administration of Aging. This three year grant focusing on long-term supports and will create an efficient, responsive, and comprehensive information and referral system to assure clients are informed of all choices for long-term supports and incorporate a seamless system for client access to all long-term care supports. Through this grant it is expected that those participating in the long-term care services covered by Medicaid will experience seamless access to all long-term support services. Major objectives will be the completion of a comprehensive web base resource directory of public and private, traditional and non-traditional services to include housing, employment opportunities and church and organizational resources and the development of critical pathways to assure informed choice. *KyHealth Choices* will build on the model and lessons learned from the ARDC grant with the intention to expand the focus to all Medicaid populations.

Chapter Five: Implementation Plan

The Kentucky Department for Medicaid Services plans to begin implementation of its 1115 Waiver (*KyHealth Choices*) in January 2006. All requirements of the Medicaid program expressed in law, regulations and policy statements not expressly waived or identified as not applicable shall apply to the *KyHealth Choices* program. The Commonwealth shall, within the timeframe specified by law, come into compliance with any changes in federal law affecting the Medicaid program that occurs after the approval date of this waiver.

KyHealth Choices is a complete transformation of the Kentucky Medicaid System. As such, the Department of Medicaid Services must be restructured to ensure full implementation of the demonstration waiver. (See Appendix A for a proposed organizational chart)

I. Waiver Administration

DMS will appoint a project manger to provide oversight and ensure structure and coordination of the on-going activities of the demonstration waiver. In addition, DMS will maintain and /or restructure existing Divisions or establish new Divisions to accomplish the following functions:

- Eligibility and Enrollment: Division of Administration and Financial Management/Eligibility Policy Branch
- Member Services: KMAA and Division of Claims Management
- Disease Management: Division of Medical Management and Quality Assurance and KMAA
- Payment Systems: (including information systems and reporting: Division of Administration and Financial Management
- Waiver Monitoring and Quality Assurance: Division of Medical Management and Quality Assurance
- Education: Divisions of Claims Management, Medical Management and Quality Assurance, Long Term Care and Community Alternatives and (KMAA).
- Finance: Division of Administration and Financial Management and Commissioner's Office Fiscal Staff Assistants.

Beginning with the administrative structure, the Department will accomplish the following tasks:

1) Administrative Structure

   a) Review the current administrative structure, including all contracted Medicaid representation in all state agencies;
   b) Identify, plan and implement changes needed in state agencies to administer the nuances of KyHealth Choices;
   c) Consider multiple programs, multiple benefit packages, and client cost-sharing, and other complexities;
   d) Develop and implement applicable interagency agreements that clearly define the roles and responsibilities of all persons and agencies involved;
   e) Identify, plan, propose and implement the administrative rules necessary for the management of KyHealth Choices.
   f) Lead a project team comprised of subject matter specialists from various state agencies including the Division of Aging, The Department of Mental Health and Mental Retardation Services and the Department of Community Based Services to monitor waiver progress; and
   g) Coordinate information system changes, work with other state agencies, providers, contractors and clients, to ensure that information, data and payment issues are addressed and necessary changes made to the systems, including testing of the systems by the implementation date.

2) Enrollment

   a) Review current eligibility/enrollment systems and processes;
   b) Develop policies on administration of enrollment caps;
   c) Identify changes needed to accommodate the increased complexity of income tracking, a more complex premium structure, multiple programs, multiple benefits packages, client cost-sharing and other new requirements of the waiver;
   d) Through the rulemaking process, identify, plan, propose and implement regulations necessary for the administration of eligibility determination, enrollment and disenrollment, data collection and data sharing for *KyHealth Choices*;
   e) Every possible effort will be made to follow the implementation plan and achieve full implementation by July 2006. Problems identified during that assessment would be dealt with through implementation plan adjustments or the designation of additional resources.

3) Delivery Systems/Provider Network

   a) Review current delivery system/provider network;
   b) Work with managed care plans and other providers to identify changes needed to accommodate the nuances implicit to any new program;
   c) Project and plan for health care needs and access-to-care issues under *KyHealth Choices*;

d) Plan for alternatives. (If existing systems cannot be accommodated under the *KyHealth Choices* plan or if access-to-care issues require other alternatives);
e) Kentucky Medicaid will assess each of its respective delivery systems and current capacities, and determine if alternative systems are needed. If needed, alternative models will be considered and implemented;
f) Technical assistance will be afforded to providers to support their efforts to accommodate the *KyHealth Choices* program and maintain access to care.

4) Payment Systems/Information

a) Review current payment systems, information systems and data systems;
b) Identify, plan for, and implement changes needed to accommodate the nuances of *KyHealth Choices* (increased use of income information, multiple programs, client cost-sharing, and other issues);
c) Identify, plan for, and implement changes needed in both state and provider systems to share necessary information. Consider HIPAA and other constraints;
d) Review current reporting requirements and reporting capabilities. Identify new reporting needs for Kentucky Medicaid, federal, state, legislative and internal;
e) Build flexibility into MMIS and other systems for future reporting needs;
f) Identify, plan for, and perform other necessary programming changes.

5) Fiscal Issues

a) Negotiate budget neutrality terms;
b) Complete and update forecasts;
c) Capitation rate setting – utilize independent actuary, work with managed care plans, set capitation rates and enter into new contracts with managed care plans;
d) Build in flexibility and monitoring capacity to expand/contract the program based on funding available**.**

II. Timeline

The Proposed waiver timeline and rollout process will occur as follows:

Phase One

Task	Timeline
Appoint project manager for the waiver.	December 1, 2006
Restructure the Department for Medicaid Services to prepare for implementation of the waiver.	December 1, 2005 - December 15, 2005

All Medicaid members excluding those in the Passport program will be moved into the 1115 waiver. The general population will move into the Global Choices plan. In addition, individuals with NF level of care will move into Comprehensive Choices plan, those with ICF/MR level of care will move into Optimum Choices plan and KCHIP and the identified children served by Medicaid will be moved into Family Choices (Please see MEG description for full details).	January 1, 2006
The Commonwealth will work with CMHCs to design service plans and goals for each of the 14 regions.	January-April 1, 2006
New level of care for Optimum Choices will begin.	July 1, 2006
RFP for Family Choices will be posted.	July 1, 2006
Begin implementation of regional behavioral service plans for the MH/MR CMHC regions.	August 1, 2006
Disease management programs for diabetes, pulmonary disease and cardiovascular disease will be rolled out	October 1, 2006
Options to strengthen HIPP will be rolled out.	November 1, 2006

Phase Two

Evaluate additional residential options such as group homes for those with acute medical needs.	July 1, 2006-January 1, 2007
Add a "middle level of care" service package focusing on assisted living.	July 1, 2007
Give members option of buying-out of Medicaid.	October 1, 2007

5) Reporting

a. Monthly Progress Calls:

The State will hold monthly conference calls with CMS to discuss progress and address questions.

b. Quarterly Progress Reports:

The State will provide a written progress report to CMS no later than 30 days after the end of each Federal Fiscal quarter, with an annual progress report provided for the fourth quarter. The report will include at a minimum:

- Events occurring during the previous quarter such as enrollment numbers, lessons learned and a summary of expenditures.
- A discussion of progress in completing program changes.
- Notable accomplishments.
- Problems and issues identified as well as actions taken to resolve them.
- Evaluation data

c. Quarterly Utilization Reports

The state will provide the following quarterly reports to CMS.

- A service expenditure report to include expenditures made under the authority of this 1115 waiver. Form CMS-64.9 Waiver or CMS 64.9P Waiver will be used for this reporting and will be submitted within 30 days of the end of each quarter. Quarterly expenditure reporting will continue for two years following the conclusion of the program for all claims for services, cost settlements or other adjustments in order to provide for a final accounting of expenditures specific to this program.
- An administrative cost report specifying expenditures for administrative costs that are directly attributable to this program.
- From CMS-37 will be used for reporting estimates to matchable Medicaid expenditures for services subject to the budget neutrality cap.
- A report on the actual number of eligible member months for demonstration eligibles

d. Annual Utilization Reports

- The state will provide a service expenditure report to include expenditures made under this 1115 waiver. The report will consist of expenditures for consumers' individual budget amounts and for the services subject to the budget neutrality cap.

e. Financial Accounting

- The state will construct and monitor a database that will consist of all participants in the demonstration. The database will be used to generate reports providing individual-level and aggregate data for all participants in the demonstration and will reconcile with CMS 64 reporting.

- Identify changes needed to accommodate the increased complexity of income tracking, a more complex premium structure, multiple programs, multiple benefits packages, client cost-sharing and other new requirements of the waiver;

Chapter Six: Evaluation and Research

Kentucky Medicaid takes seriously the evaluation component of the demonstration and is anxious to develop meaningful data and analyses that can guide the program as it evolves. Accordingly, Kentucky Medicaid intends to utilize the evaluation process as a part of its continuous quality improvement activities, taking the opportunities inherent in the process to garner substantial information on the effects and impact of the demonstration on the lives of its participants and the long-term care system in general.

Central to Kentucky's responsibility to provide on-going assessment and improvement to the quality of services to its members is the evaluation of the waiver program. This evaluation will occur on a number of levels to provide pertinent data and feedback to the stakeholders.

DMS will conduct an evaluation of the Demonstration. The evolution of the Demonstration will be guided in large part by the evolution of services and delivery processes using information gained through this quality monitoring.

Kentucky expects to use clinical, functional and cognitive measures from assessments of member experiences and services. The Commonwealth anticipates developing and utilizing longitudinal as well as point in time assessments. These will be service, condition, and delivery system oriented.

The Commonwealth will also develop and utilize financial measures of services delivery, looking at whether the Demonstration is achieving lower overall costs than traditional Medicaid has incurred on a per member, per condition or per delivery system.

Measures of efficiency, efficacy and optimality will be developed by DMS to guide the monitoring and evaluation process.

Hypotheses
It is expected that by implementing *KyHealth Choices* the following will occur:

- The opportunities for choice in services will increase for specific plans;
- The percentage of members who participate in healthy behaviors will increase;

- The percentage of hospitalizations in the mental health delivery system will decrease;
- The use of nursing facilities and ICFs/MR will decrease while community based services will increase;
- Member satisfaction with services will increase;
- The number of uninsured individuals in Kentucky will decrease; and
- The rate of growth of the Kentucky Medicaid program will stabilize.

Evaluation Objectives

KyHealth Choices seeks to provide an opportunity to implement and evaluate innovative and market-driven approaches to transforming the Kentucky Medicaid program. In keeping with this, three key objectives and accompanying research questions have been identified.

1. Access to Care
   a. To what extent do members report improved access to a full range of health care services?
   b. To what extent will the Commonwealth realize a reduction in the number of members without insurance coverage?
   c. To what extent did access to preventive and wellness programs increase?
   d. To what extent did the use of disease management programs increase?

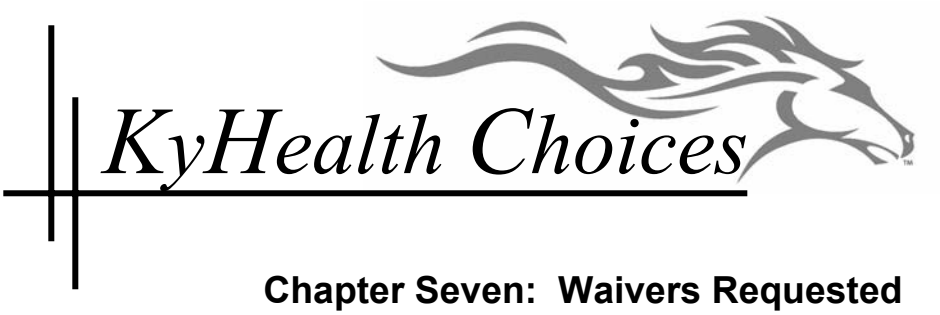
2. Quality of Care
   a. To what extent do members report satisfaction with services?
   b. What is the self-reported health status of the member?
   c. To what extent do members self report improved health status due to incentives?
   d. To what extent do providers report improved healthy status of members due to get healthy incentives?
   e. To what extent will a review of medical records show better health status?

3. Design and Implementation
   a. What impact did the waiver have in improving the health status of individuals?
   b. What impact did the waiver have on decreasing costs?
   c. To what extent did the use of “high end” medical services decrease?
   d. To what extent the GHAs increase health lifestyles?
   e. To what extent did the implementation of premiums and co-pays affect utilization of services?
   f. To what extent did the self-directed options affect utilization of services?
   g. To what extent did the self-directed options affect cost?

Data Sources
Several data sources may be used to test the success of the demonstration waiver. Potential data sources to be used could include:

- Case study interviews
- Surveys
- Medical records and clinical indicator analysis
- Plan and provider surveys and reports
- On-going program monitoring

Methodologies
Various methodologies may be used to answer the research questions and address the hypotheses. The state expects to conduct both qualitative and quantitative analyses and is considering pre and post surveys. Additionally, the state expects to utilize the waiver team representatives to assist in gathering lessons learned from initial implementation as well as case studies for specific plans.



Chapter Seven: Waivers Requested

In order to administer the demonstration described in this proposal, the Commonwealth of Kentucky will require the following waivers for statutory and regulatory requirements of the Title XIX of the Medical Assistance Program:

1902(a)(1) -- The Commonwealth requests a waiver of the Statewideness requirements set forth in this Section so that it can be permitted to offer different services in different geographic regions of Kentucky.

1902(a) (8) – The Commonwealth requests a waiver of the Reasonable Promptness requirement so that a waiting list for individuals eligible for Optimum Choices and Comprehensive Choices service packages can be maintained.

1902(a) (10) -- The Commonwealth requests a waiver to provide Non-Medicaid State Plan services to the Demonstration population.

1902(a)(10)(a) -- The Commonwealth requests a waiver to modify the Medicaid benefits package and to offer a different benefits package based on condition and treatment than would otherwise be required under the state plan to mandatory Medicaid eligibles, to enable the Commonwealth to limit the scope of services for optional eligibles.

1902(a)(10)(A) and 1902(a)(C)(10)(i) -- The Commonwealth requests a waiver of these Sections in order to permit it to use streamlined eligibility procedures, along with streamlining the Medically Needy process, and to include eligibility standards and requirements that differ from those required by law.

1902(a)(10)(B) -- The Commonwealth requests a waiver of the Comparability requirements set forth in this Section to permit it to provide services to individuals under the waiver that are not available to Medical Assistance recipients who are not enrolled in the waiver and to impose different levels of resources for persons electing home-based care and services.

1902(a)(10)(b) -- The Commonwealth requests a waiver to permit it to restrict the amount, duration, and scope of services provided to a Demonstration enrollee to those services included on the participant's approved plan of care.

1902(a)(10)(C)(i)(III) -- The Commonwealth requests a waiver of this Section to use institutional income and resource rules for the medically needy, with resource limits set at $10,000 for enrollees electing home-based services in lieu of nursing facility or other residential care services in state-licensed settings.

1902(a)(14) -- The Commonwealth requests a waiver of this Section to enable it to impose cost sharing on certain services.

1902(a)(17) -- The Commonwealth requests a waiver of this Section in order that only the individual's income and resources will be considered when applying for the Waiver and to offer one (1) month spend downs for participants receiving community-based services as an alternative to institutionalization. In addition, this waiver will permit the Commonwealth to disregard quarterly income totaling less than $20.00 from post-eligibility income determination.

1902(a)(23) -- The Commonwealth requests a waiver of this Section so that it can restrict freedom of choice of provider by offering benefits only through managed care plans (and other insurers) and by requiring beneficiaries to enroll in managed care without a choice of managed care plans.

1902(a)(32) -- The Commonwealth requests a waiver of this Section in order to permit payments for incidental expenses to be made directly to Demonstration participants or their representatives.

1902(a)(32) --The Commonwealth requests a waiver of this Section to enable it to provide reimbursement, through tax credits offered through the Kentucky Revenue Cabinet, to individuals purchasing qualified individual long-term care policies.

1902(a)(4)(A) (as implemented by 42 CFR 431.804, 431.806(a), 431.8100-0431.816, 431.820-431.822, and 431.865 except that the regulatory definitions of "claims processing error" and "state agency" will continue to be applicable) -- The Commonwealth requests this waiver in order to enable it to employ a Medical Eligibility and Quality Control System that varies from that required by the cited statute.

1902(a)(10)(C)(i)(III) - The Commonwealth requests a waiver of this Section to use institutional income and resource rules for the categorically needy, with resource limits set at $10,000 for enrollees electing home-based services in lieu of nursing facility or other residential care services in state-licensed settings.

1902(a)(10)(C)(i)(III) - The Commonwealth requests a waiver of this Section to use institutional eligibility and post eligibility rules for individuals in the community who, but for the provision of home and community-based like services, would require nursing facility level of care.

1902(a)(10)(C)(i)(III) - The Commonwealth requests a waiver of this Section to cover individuals in the community with income up to 300% of the SSI/FBR and who, but for the provision of home and community-based like services, would require nursing facility level of care.

1902(a)(10)(C)(i)(III) - The Commonwealth requests a waiver of this section to apply spousal impoverishment eligibility and post eligibility rules to individuals in the community who, but for the provision of home and community-based like services, would require nursing facility level of care.

Chapter Eight: Financial

Budget neutrality calculations and spreadsheets maintained separately.

Per Capita Request
Kentucky is requesting an 1115 waiver based on per capita expenditures.

Compliance and Budget Neutrality
Pursuant to Section 1115 of the Social Security Act, a state must demonstrate that a proposed waiver program will not cause federal expenditures to increase beyond what they would have been under traditional Medicaid rules over the waiver period. Cost neutrality for the waiver program is predicated on this number of participants. Should the program prove to be such a success that this enrollment number is greatly exceeded, or if the average cost per individual is significantly greater than originally anticipated, the program will be under-funded at the state level and the Department will be unable to demonstrate cost neutrality.

Caps
The Department does not request capping its *KyHealth Choices* waiver program. The Commonwealth of Kentucky will inform CMS of any planned changes in this area.

Adequacy and Reimbursement

Access to services is available in every area of the state. To monitor the adequacy of the finance and reimbursement methods plans, the state evaluates the capacity of these programs through a capacity reporting process. The Department also conducts annual surveys of both providers and members. These surveys show that providers are satisfied with the financing and reimbursement process of the Department. The vast majority of members report that they are able to get needed care. Similarly, capacity reports are compiled for MCOs on a quarterly basis. Additionally, Department staff review MCO specialty care provider networks. The Department makes every effort to correct access problems as they are identified.

Chapter Nine: Future Planning

KyHealth Choices will be divided into two phases. During Phase II of the waiver, should the funds become available, Kentucky plans to implement several unique initiatives. These initiatives will include the following:

- Expand substance abuse services. Priority populations under this expansion will begin with mothers with substance abuse issues, followed by co-occurring and adolescents.

- Augment personal care attendant and supported living programs to maintain the flexibility of the programs while stretching dollars.

- Expand disease management programs to include peer support and peer counseling services.

- Expand crisis stabilization to include individuals with mental retardation and other developmental disabilities. Expand the Supported Living model.

- Increase housing option and alternatives to institutionalization.

- Increase the physician payment fee schedule to recognize the increasing cost of providing healthcare services.

- Explore contracting dental services to a private dental carrier(s) for administration similar to commercially available carve out policies. Minimum benefits will be specified and the policy will be available as an added premium available for purchase by adult members. Children will automatically be enrolled in the plan.

- Increase the continuum of care for Optimum and Comprehensive Choices

- Continue evaluating options allowing individuals to be served in the least restrictive setting possible, i.e. supported living arrangements or their natural home.

- Reduce the number of people without insurance by offering, at a minimum, an in-patient and out-patient benefit to low-income Kentuckians who are currently uninsured. This will not be an expansion of Medicaid but a stand alone product focused on a network of publicly funded providers.